NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora A Rohe O Te Tai Tokerau

ANNUAL PLAN 2016/17

incorporating

STATEMENT OF PERFORMANCE EXPECTATIONS 2016/17

and

STATEMENT OF INTENT

Signatories

Agreement dated this 6th day of 12 2016

between

.....

Her Majesty the Queen
In right of her Government of New Zealand
Acting by and through the Minister of Health

Minister of Health

Anthony Norman
Chair, NDHB

Sally Macauley
Deputy Chair

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Chief Executive, NDHB

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1 Introduction

1.1 Executive Summary

Northland District Health Board will continue to improve the delivery of services during 2016/17 while living within our means.

The Board has maintained a balanced financial position since 2003 and will continue to operate within a viable and financially sustainable cost structure. Northland DHB is committed to the Government's aim of delivering better public services within tight financial constraints, and to the four objectives of the Government's health plan: helping families stay healthy, better performance, best use of the health dollar, and a strong and trusted workforce.

We will continue to strive to improve our performance on the Health Targets. We now meet or exceed targets for elective services, advice to smokers in hospital generally and in maternity services, and in heart and diabetes checks. We are close to target for advice to smokers in primary care and heading ever closer to target in immunisation rates. Though we are still below target for the new 62-day faster cancer treatment indicator (as are all DHBs), our performance is improving steadily and we expect to be close to target by quarter four 2015/16. Our performance on ED waiting times remains below target, and although work on service improvement is ongoing, demand continues to increase. Northland DHB will contribute towards reducing the incidence of rheumatic fever and family violence, two of the ten whole-of-government key result areas, and remain a leader in developing and implementing Children's Action Plans.

The Annual Plan incorporates activities under the five major projects initiated under the Northland Health Services Plan, our template for the future structure and provision of services across the whole health sector in Northland. Our system-wide approach is aimed at providing more coordinated and prioritised services closer to home for our at-risk populations. We are supporting up to eight practices to develop into *Neighbourhood Healthcare Homes*, new models of care which better integrate services across the health sector, and in which multidisciplinary teams support networks of general practices. *Fit for Life* is developing a local plan for a coordinated, cross-sectoral approach for dealing with childhood obesity. *First 2000 Days* is concentrating on changing systems to enable all children to have the best start in life, beginning in pregnancy. *Patient and Whanau Centred Care* focuses on consumer engagement and changing the culture within Northland DHB. *Integrated Urgent Healthcare* aims to improve hospital care for our acutely unwell, as well as identifying and addressing unmet need for same-day access to primary care for people with urgent health needs.

These approaches are vital to meet the challenges posed by our ageing population, the rising tide of long term conditions, our rurality and the relative poverty of our citizens.

Northland DHB continues to work with primary and community services to deliver integrated services for older people to support them living independently in the community, manage long term conditions well and prevent admission to hospital. We are also continuing to improve the quality of residential care services (including dementia care), and stroke services.

The Annual Plan is closely aligned with the Northern Region Health Plan. Its Triple Aim of improving population health, patient experience and value/ sustainability formed the starting point for the Northland Health Services Plan. Relevant regional performance measures have been integrated into the Annual Plan. Regional planning processes, in which Northland DHB staff have been intimately and prominently involved, continue to develop models, pathways and protocols to guide future improvement across all four DHBs.

Improving Maori health and reducing inequities continue to be driving forces. The Maori Health Plan 2016/17, a companion document to the Annual Plan, sets out key performance measures for health services. Maori health and reducing inequities are addressed throughout the Annual Plan and they form a headline target under the Northland Health Services Plan. Northland DHB continues to strengthen internal and external monitoring systems so that all indicators, including Health Targets, will be reported by ethnicity. Increasingly we are using a results based accountability framework for monitoring provider performance on population health measures.

Northland DHB recognises that working with our intersectoral partners is essential to improving the lot of Northlanders. We will continue our membership of the Northland Intersectoral Forum and are working

with several governments under the aegis of the Social Wellbeing Governance Group to set up a social investment initiative focussed on vulnerable children, young people and their families. We are also working with the Ministry of Social Development and other organisations on improving access to mental health services and reducing substance abuse in Otangarei, a suburb of Whangarei, to improve the employment prospects of the area's residents.

This year's Annual Plan projects a balanced budget. Northland DHB has a continuing commitment to improving efficiency and investing upstream to reduce demand for and the cost of expensive hospital care. Significant savings are factored into the plan from our own initiatives, procurement and supply chain business case, and healthAlliance procurement savings.

The Annual Plan has been developed with the involvement of the Chief Executives of Northland's two PHOs, both of whom have indicated their support for the plan on the signatures page, and who are also members of Northland DHB's Executive Leadership Team.

1.2 Context

1.2.1 Background and operating environment

Legislation

Northland DHB is one of 20 District Health Boards established in 2001 in accordance with section 19 of the Public Health and Disability Act 2000. Section 22 of the Act requires Northland DHB to:

- improve, promote, and protect the health of people and communities
- promote the integration of health services, especially primary health and hospital services
- promote effective care or support for those in need of personal health services or disability support services
- promote the inclusion and participation in society and independence of people with disabilities
- reduce health disparities by improving health outcomes for Maori and other population groups
- uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations.

DHBs are categorised as Crown agents under section 7 of the Crown Entities Act 2004. As well as preparing an Annual Plan, Northland DHB must prepare a Statement of Intent according to section 139 of the Crown Entities Act.

DHBs have a statutory responsibility under the Treaty of Waitangi to put into practice its principles of partnership, protection and participation. NDHB is acutely conscious that Maori, who comprise about a third of our population, suffer most from health and other inequities.

Ability to enter into service agreements

In accordance with section 25 of the New Zealand Public Health and Disability Act, Northland DHB is permitted by this Annual Plan to:

- negotiate and enter into service agreements containing any terms and conditions that may be agreed
- negotiate and enter into agreements to amend service agreements.

We have no plans to enter into a body cooperative agreement or arrangement, or to acquire shares or interests in any body corporate, trust, joint venture partnership and/or other association of persons, to settle or appoint a trustee of a trust, and any processes to be followed and requirements to consult with the Minister. We note the disestablishment of HBL and that this may (or may not) have implications for the transfer of existing shares (or purchase of new shares) in its successor.

The health system

The Ministry of Health's Outcomes Framework provides the context for DHBs. The health system is driven by their two overarching outcomes of "New Zealanders living longer, healthier, more independent lives" and "the health system is cost effective and supports a productive economy". Contributing to these are the Ministry's three high-level outcomes of "New Zealanders are healthier and more independent", "health services are delivered better, sooner and more conveniently" and "the future sustainability of the health system is assured".

In working towards these, the Ministry contributes to the Government's overall national priorities of "better public services", "a more competitive, productive economy" and "responsibly managing government finances".

Our population

Northland's estimated population in 2016 is 170,000, 3.7% of New Zealand's population. About half live in the Whangarei District Council area, 37% in the Far North District Council and 13% in Kaipara District Council. Nga Iwi o Te Tai Tokerau comprise 30% of Northland's population.

Northland's population is 'ageing' because those aged 65 or more are forming an increasing proportion of the population. At the moment this sits at 19.1%, higher than the national average of 15.1%. By 2026 older people will comprise 24.9% of Northland's population, a 5.8% increase (while New Zealand's growth will be only 4.1%).

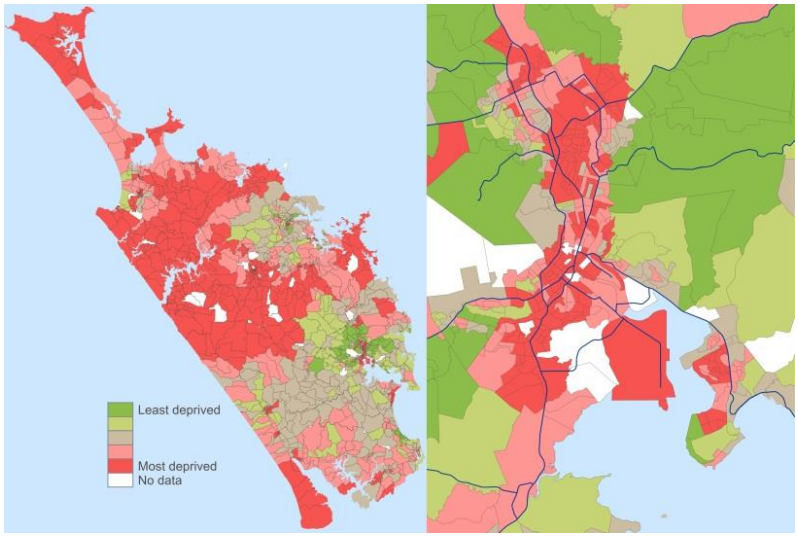
The child and youth population declined by 1% between 2013 and 2016 from 33.9% to 32.9%. However the Maori birth rate is about two-thirds higher than the non-Maori rate, so the numbers of Maori babies will not be declining for the foreseeable future.

Our health

The health status of Northlanders is among the lowest in the country. Non-Maori Northlanders' health is generally comparable to that of non-Maori nationally, but Northland Maori uniformly fare worse. Maori life expectancy in Northland is 9 years less than non-Maori (whereas nationally the difference is 7.6 years), and the average age of Maori admitted to hospital is 13 years younger than that of non-Maori.

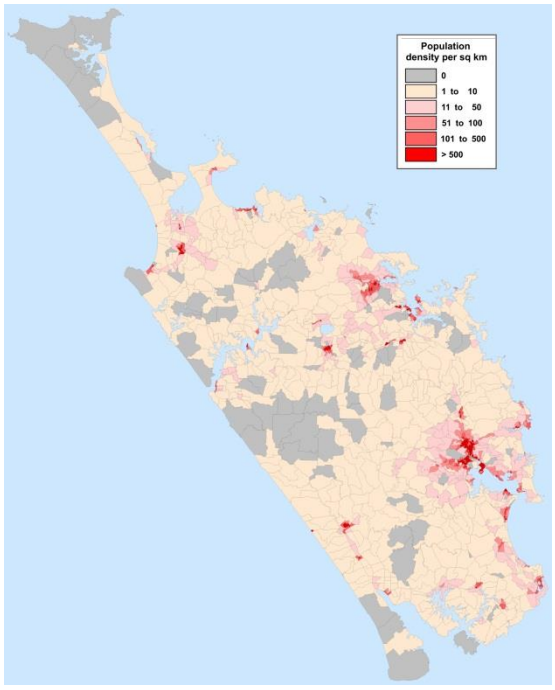
Poorer populations have lower health status, and Northlanders are among the most deprived in the country. The 2013 national deprivation index placed 20% of the nation's population in its lowest band (quintile), but for Northland the figure was 37%. The most deprived local authority area is the Far North District Council with 50% in the lowest quintile. Deprived populations tend to be less health literate.

NZDep 2013 in Northland

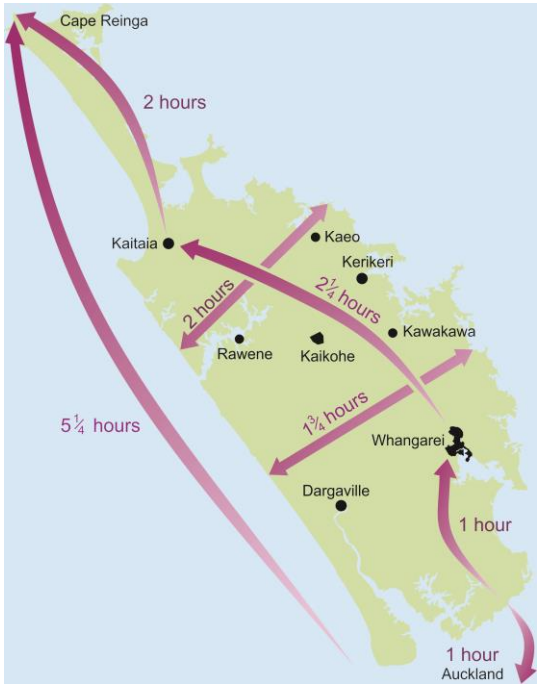


Northland's population is thinly distributed. About one-third lives in the Whangarei urban area and another 13% lives in the towns of Kaitaia, Kerikeri, Kaikohe and Dargaville, each of which have about 5,000 people. The other 55% or so of the population is scattered across the length and breadth of Northland in small communities and rural areas.

Population density per square kilometre



The combination of a thinly dispersed population and lengthy travelling times (the result of long distances and often poor roads) makes access to services a problem for many people. Generally, those who live furthest away from services are the most deprived.



The highest demands placed on health services, and the most common causes of death, come from long term conditions, which include cancers, heart disease, stroke, diabetes and respiratory disease. Many of the risk factors they have in common, such as smoking and obesity, are more prevalent in socioeconomically deprived populations.

These 'lifestyle conditions' occur more frequently with age, the main reason our ageing population is a major challenge. The older section of our population consumes several times more health resources than others in the population.

Two-thirds of Northland's population lives in rural towns and areas outside the Whangarei urban area, many in isolated areas accessible only by unsealed roads. It takes over five hours to travel from Northland's northern to southern extremities and up to two hours west to east. For many Northlanders, travelling to where health services are located poses a challenge, especially for the most isolated areas which tend to have high needs.

1.2.2 Nature and scope of functions

Services provided

Northland DHB provides public health, primary and hospital (secondary) services to our population. These include medical, surgical, maternity, mental health and addictions, rehabilitation, child health, youth health, oral health, diagnostic services (imaging, laboratory) and clinical support services (pharmacy, physiotherapy, occupational therapy and so on).

Providing services to a moderate-sized population over an area the size of Northland is one of the biggest challenges for Northland DHB and other providers in the health sector – particularly so when we know that generally the more distant a population, the greater its health needs.

As a mid-sized DHB, Northland is not large enough to be able to provide more specialised (tertiary) services; for these we rely on other DHBs, mainly Auckland.

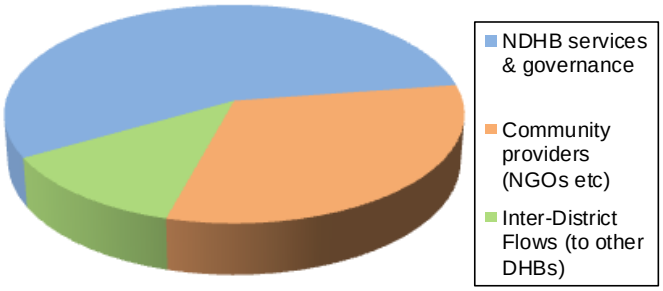
Northland DHB holds agreements with over a hundred primary and community organisations which provide a wide range of public health, primary and community services.

Northland DHB has responsibility under the Public Health and Disability Act for the overall planning of health services in Northland. This entails assessing health needs in the population and matching these with the best combination of service types and distribution we can afford.

NDHB retains stewardship of crown assets valued at $206 million (2014/15 balance sheet). These consist of freehold land and buildings ($144 million), plant, equipment and vehicles ($10 million), work in progress ($23 million) and investments ($29 million).

Significant activity has occurred to improve the capital infrastructure in Whangarei. Among other site infrastructure improvements a new administration block opened in May 2015 and a new maternity unit in February 2016. The IT programme for the year has three themes: completion of the multi-year programme to upgrade the core hospital clinical systems; ongoing support for the clinically-led initiatives to co-design care models across the district (such as Neighbourhood Healthcare Homes); continued improvements in IT resilience and access. Northland DHB is also involved in the development of Integrated Family Health Centres sites in Dargaville, Kawakawa, and Whangarei (Kensington and Raumanga) and improvements to Bay of Islands Hospital in Kawakawa.

Share of health funding in Northland



Out of Northland DHB's total 2016/17 budget of $595M, over half (56%) is spent on NDHB-provided services, about a third (32%) on community provider services, and the rest (12%) is paid to other DHBs for tertiary services through inter-district flows.

Governance

Governance of NDHB is provided by a Board of eleven, of whom seven are elected and four appointed by the Minister of Health.

The Chief Executive is responsible to the Board for the organisation's performance.

1.3 Strategic Intentions

NZ Health Strategy

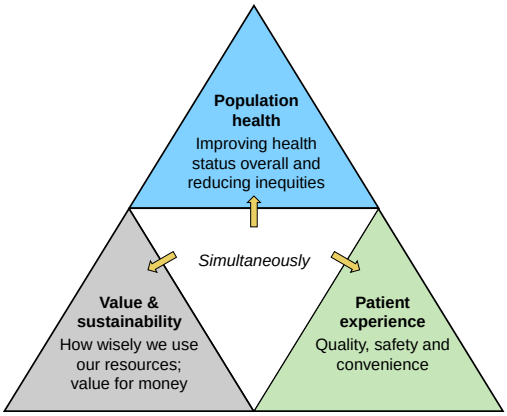
The NZ Health Strategy, released late in 2015, is currently undergoing revision in the light of feedback during its consultation phase. It recognises that New Zealand's health system needs to undergo radical change if it is to address changing needs and issues. Particularly it needs to deal with the ever-increasing prevalence of long term conditions (especially diabetes and cancer), obesity and the ageing population while also addressing inequities of health status and access. If nothing is done, health spending as a percentage of GDP will rise from just under 7% to about 11% by 2060.

The Health Strategy envisages a "fit for the future" system that will enable:

> "…all New Zealanders [to] live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system.

Northland Health Services Plan

The Northland Health Services Plan (NHSP) embodies Northland DHB's strategic intentions. The plan was developed around the Triple Aim framework, ensuring that all assessments and decisions are made by simultaneously balancing population health, patient experience, and value and sustainability.



Each of the Triple Aims has two Headline Targets for 2017 which drive the NHSP:

Population	The life expectancy gap between Maori and non-Maori is reduced by 2 years

health	Unplanned hospital admissions for Northlanders are reduced by 2,000
Patient experience	Every Northlander with urgent health needs has same-day access to primary care
	More than 95% of patients report they would recommend the service provided
Value and sustainability	Value for money savings of $5M are achieved against projected cost increases each year
	Northland hospital labour productivity benchmarks in the top five DHBs

Detail on the NHSP's five major projects is available in sections 2.3.1 to 2.3.5.

Clinical leadership

Clinical leadership is key to how NDHB works. Clinicians form an integral part of NDHB's management structures (described further in 5.3 Clinical Leadership), and are active participants in Northern Region groups and processes. Northland's PHOs also have clinicians as prominent members of their organisations.

Working with others in the social sector

Northland DHB is involved in several social sector activities, including the Social Sector Trial in Kaikohe for youth, Make it Happen Te Hiku, Youth Suicide Prevention, a place-based project in Otangarei, the Social Wellbeing Governance Group and its Children's Teams, a social investment project and the Northland Intersectoral Forum. (Some of these are covered in 2.18 Intersectoral action).

Northern Region Health Plan

Northland DHB's priorities are consistent with those of the Northern Region Health Plan (see below).

Intervention logic

Northland DHB deals with several planning streams which are aligned as described in the diagram at the end of this section.

New Zealand Health Strategy

Once finalised, this will drive the future direction of health services in New Zealand.

National priorities

National priorities are determined by the Minister of Health and Ministry of Health.

A subset of the national priorities, those that focus mainly on secondary and primary clinical services, drive the Northern Region Health Plan. This sets the strategic framework for Northland's clinical services, especially hospital services.

The Northern Region Health Plan (NRHP)

The Northern Region Health Plan provides an overall framework to demonstrate how the Government's objectives and the region's priorities for regional work will be met during 2016/17 and beyond.

The Northern Regional Alliance oversees the NRHP. NRA continues to ensure regional alignment of plans and appropriate stakeholder representation and involvement by having clinical network and workgroup memberships drawn as appropriate from each of our region's DHBs and with representation from across the primary-secondary continuum of care.

The overall direction and strategic intent of the 2016/17 Northern Region Health Plan will be to:
- achieve gains across the Triple Aim Framework
- reflect the themes of the New Zealand Health Strategy.

Regional focuses for 2016/17 include:

Supporting achievement of the National Health Targets

A particular emphasis on three areas of work for accelerated gains:
- child health

- health of older people
- equity (which will be an emphasis across each area of regional work).

Regional collaborative work to enhance outcomes, develop new models of care, drive process consistency by means of Regional Clinical Networks:

- cancer
- cardiovascular disease
- diabetes
- major trauma
- mental health and addiction
- stroke
- youth health.

Regional service changes and other regional service planning with a particular emphasis on:

- the implementation of a supra-regional Eating Disorders Services (EDS) Hub
- the new national hepatitis C initiative to implement a clinical care pathway, assessment and treatment services across the region
- local oncology service delivery where we will investigate the options for transitioning some high volume medical oncology service elements between service providers
- hyper-acute stroke services; improvements to models of care and service implementation plans
- electives, and maintaining achievement of the reduced elective services wait time target
- Advance Care Planning, improving communication between patients and whanau/ families and clinicians around end-of-life care and treatment.

Enablers of service delivery with emphasis on:

- information systems
- workforce
- facilities (and long term investment planning).

Annual Plan

The Annual Plan covers all the national priorities and is consistent with the NRHP and the Maori Health Plan.

Northland Health Services Plan

The Northland Health Services Plan incorporates all the above and more. Built upon a health needs assessment, it takes a global, system-wide view and considers measures that will lift the health of the population and improve the way the health system works.

Statement of Performance Expectations

The Statement of Performance Expectations (SPE), a subset of the Annual Plan and the backbone of the Statement of Intent, draws elements from all the other plans. The SPE's highest-level outcomes and measures are consistent with the NHSP's outcomes and headline targets. It is substantively consistent with the NHSP's five major projects.

Vision and mission

Northland DHB's vision: "A Healthier Northland / *He Hauora Mo Te Tai Tokerau*"

Northland DHB's mission: Achieved by working together in partnership under the Treaty of Waitangi to:

- improve population health and reduce inequities
- improve the patient experience
- live within our means.

Mahi tahi te kaupapa o Te Tiriti o Waitangi he whakarapopoto nga whakaaro o te Whare Tapa Wha me te whakatuturutahi i te tino rangatiratanga te iwi whanui o Te Tai Tokerau.

Alignment of national, regional and local planning frameworks

	National	Regional	Local
Outcomes	**National Outcome** All New Zealanders live longer, healthier, more independent lives	**NZ Health Strategy themes** *1:* People powered *2:* Care closer to home *3:* High value and performance *4:* One team *5:* Smart system	**Regional Outcome** Improve health outcomes and reduce disparities by delivering high quality, high value, and better integrated services. We will do this in a way that meets future demand while living within our means.	**NDHB Vision:** A healthier Northland. **NDHB Mission:** Working together in partnership under the Treaty of Waitangi to improve population health and reduce inequities, improve the patient experience, and live within our means.

Northland Health Services Plan Headline Targets

Population Health	Life expectancy gap between Maori and non-Maori reduced by 2 years Unplanned hospital admissions reduced by 2,000
Patient Experience	Everyone with urgent health needs has same-day access to primary care More than 95% of patients recommend service provided
Value and Sustainability	Value for money savings of $5M against projected cost increases each year Northland hospital labour productivity benchmarks in the top five DHBs

Statement of Performance Expectations outcomes

Healthy population	Prevention of illness & disease	Reversal of acute conditions	Optimum quality of life for those with LTCs	Independence for those with disabilities

Priorities	**Ministerial priorities 2016**						
	NZ Health Strategy	Live within our means	Work across Govt	Health Targets	Obesity	Shift & integrate services	Health IT Programme

Statement of Performance Expectations impacts

Smoking cessation	Healthy children	People manage in the community through effective primary care	Symptoms of long term conditions, ameliorated or delayed	Increased likelihood of survival from cancer , reduced severity of symptoms

Mental disorders: impacts minimised for clients and whanau	Elective surgery: fewer debilitating conditions	More timely care in emergency departments	Higher quality and safer services	Older people receive services appropriate to their needs

2 Priorities

2.1 Alignment with the New Zealand Health Strategy

The five themes of the New Zealand Health Strategy – section headings 2.1.1 to 2.1.5 below – reflect activities and approaches that have been pursued in Northland for some years now. Each of the five themes below comprises several components, against each of which are listed key actions from the Annual Plan. This is a representative sample across all the sections; it would take up too much space to list all relevant actions because most of them relate in some way or other to the themes and their components. To save space, longer actions have been abbreviated while still retaining the gist of them.

2.1.1 People powered

Theme components	Annual Plan section and action	
Understanding people's needs and wants and partnering with them to design services to meet these	2.2.2 Improved access to elective surgery	3 Reduce DNA rates in our community through the identification and implementation of a patient-centred approach to booking. Proceed with review and implementation of patient centred booking process in clinics in 2016.
	2.3.3 Primary Options	*(Three actions about collaborative work across the PHOs and NDHB.)*
	2.4.4 HOP Dementia Care Pathway	2 Provide detailed information of dementia education and support programmes in operation to support informal carers and people living with dementia (as per the NRHP) engaging with consumers and whanau to assess equity of access by ethnicity, locality, source, acceptability, variability and sustainability.
	2.9 Whanau Ora	8 Quality Improvement Directorate provides qualitative data on patient and whanau satisfaction with health services.
	2.13 Quality and safety	1 Identify opportunities from the 'at the bedside' patient surveys to improve care. 34 Continue the Patient and Whānau Centred Care programme.
Encouraging and empowering people to be more involved in their health, by engaging with them about their wellbeing and helping to make healthy choices easy	2.6.1 Maternal & child health	18 Continue to fund and support Project Energize in participating primary schools; extend the programme to more schools.
	2.7 Youth health	23 Ensure youth are considered and consulted in the development of the Northland Sexual and Reproductive Health Plan 2016.
	2.8.1 Diabetes	4 Implement systems and processes to identify prediabetes in at-risk groups and initiate plans for early intervention.
	2.8.4 Stroke	1 Support any public education campaigns about stroke, such as Face, Arm, Speech, Time (FAST).
	2.9 Whanau Ora	6 Te Roopu Kai Hapai Oranga (Northland Alliance Leadership Team) commit to collective decisions to dedicate resources and effort to Maori whanau.
Communicating well and supporting people's navigation of the system, by building health literacy, as well as using technology such as mobile phones and the internet	2.2.4 Increased immunisation	8 Increase health literacy on immunisation for health professionals.
	2.6.1 Maternal & child health	4 Increase health literacy for Maori whanau, focusing on pregnant women and parents with young children…
	2.2.2 Improved access to elective surgery	3 Reduce DNA rates in our community through the identification and implementation of a patient-centred approach to booking.
	2.7 Youth health	19 Develop and articulate transition pathways by service (such as mental health, alcohol and other drugs, long term conditions) from child to youth and youth to adult services.
	2.8.4 Stroke	4 Complete and implement changes to existing community A&R programmes to improve flow of patients from inpatient to community

Theme components	Annual Plan section and action	
		environments, completing a hospital-to-home rehab pathway by Q3.
	2.9 Whanau Ora	3 Whanau Ora Collectives and providers support Maori whanau to navigate systems within health and social sector to ensure they receive quality services, particularly in the five key areas of mental health, asthma, oral health, obesity and tobacco in primary.

2.1.2 Care closer to home

Theme components	Annual Plan section and action	
More integrated health services, including better connections with wider public services *[The actions under the first component under 2.1.4 also apply here.]*	2.2.5 Better help for smokers to quit	22 The Smokefree team will continue to work with member agencies of the Northland Intersectoral Forum in the development of their smokefree policies and associated actions in support of the Smokefree 2025 goal.
	2.3.2 Neighbour-hood Healthcare Homes	1 In collaboration with the two PHOs support for up to 8 practices/ networks to develop into NHHs.
	2.3.7 Community pharmacy	2 Community pharmacy will be represented at Northland's Rural SLA,T further developing strategic opportunities to develop a multidisciplinary approach to shifting service to the community under a primary care setting enabling pharmacists to operate at the top of their scope.
	2.4.1 HOP system integration	1 Continue to increase the number of contacts and exchanges of information between the HOP Gerontology Nurses and GPs and primary health care teams.
	2.4.2 HOP interRAI	5 Continue to identify opportunities for the application of InterRAI assessment across the continuum of care, and other primary and community settings.
	2.4.5 HOP falls and fractures	4 Participate in Fracture Liaison Service planning days in conjunction with other DHBs' Fracture Liaison Nurses, ACC, HQSC, MOH and Osteoporosis NZ to standardise guidelines, risk assessment, protocols and datasets.
	2.5 MHAS	2 Establish an integrated across-sector (including NGO and PHO) MHAS philosophy and model of care that is recovery-oriented and outcomes-focused 20 Collaborate with Health of Older People Services to provide an integrated dementia clinical pathway. 21 Trial a clinical nurse specialist liaison role between MHAS and the residential aged care sector to reduce crises and demand for acute services, and improve care for older people with high and complex needs.
	2.7.1 Youth health	2 Continue pilot Youth Health Assessment project in association with Kaikohe Social Sector Trial.
Investment early in life and a focus on children, young people and families and whanau	2.2.6 Childhood obesity	*All 6 actions.*
	2.3.2 Neighbour-hood Healthcare Homes	1 In collaboration with the two PHOs support for up to 8 practices/ networks to develop into NHHs.
	2.5 MHAS	23 Develop a referral pathway (in conjunction with NRA) for Autism Spectrum Disorder, Fetal Alcohol Spectrum Disorder and conduct disorder in collaboration with Child Health Services. 35 Review the acute care continuum (including IPU, crisis, DAO, sub-acute, respite, meds run) for adults, children and youth and older people to develop the most effective and efficient model of care and service delivery across the district.
	2.6.1 Maternal & child health	*All 18 actions*

Theme components	Annual Plan section and action	
	2.6.2 Rheumatic fever	*All 12 actions*
	2.6.3 Vulnerable Children	*All 12 actions.*
	2.7 Youth health	*All 23 actions*
Care closer to where people live, learn, work and play, especially for management of long-term conditions	2.2.2 Improved access to elective surgery	2 Increase use of the regional operating facility in Kaitaia.
	2.2.4 Increased immunisation	2 Continued monitoring of individual children to result in timely vaccination utilising the newly implemented monitoring tool, inclusive of 8-month, 2-year-old and 5-year-old children.
	2.3.7 Community pharmacy	1 Continue to work closely with the Northland Community Pharmacy Services Development Group and build upon the Pharmacy Action Plan to identify further opportunities for pharmacies to offer treatment, health literacy and services to patients closer to home that will contribute to eliminating inequities for Maori. NDHB will continue to participate in the national process to commission services in the community that cost-effectively match supply to need. 7 Support the work being undertaken by all DHBs to develop a National Framework for Pharmacist Services in the community, ensuring that Northland's populations needs are met
	2.3.8 Rural SLAT	2 Under direction of the Rural SLAT evaluate current out-of-hours service provision and design sustainable and accessible models of care that reduce inequities and purchase services from general practice that meet these needs.
	2.5 MHAS	28 All service users and families will be provided with information about mental illness and addictions, MHA services, and health and wellbeing.
Focus on wellness and prevention of long-term conditions through both population-based and targeted initiatives	2.2.5 Better help for smokers to quit	*Actions 8 – 37 about helping people stop smoking by supporting general practices, maternity services, mental health services, other secondary services and through public and population health initiatives.*
	2.2.6 Childhood obesity	1 When Ministry funding is confirmed, and new services designed with stakeholder engagement, quarterly milestone and planned activities will be agreed to roll out, fully embed, promote and utilise the newly established intervention programmes that offer high quality outcomes to tamariki and whanau who have been referred for additional support. The service will demonstrate high levels of collaboration between the DHB, PHOs and community partners to ensure whanau experience a seamless transition between services.
	2.3.1 Fit for Life - obesity	1 *All 7 actions*.
	2.4.5 HOP falls and fractures	6 Continue with promotion of education around osteoporosis and fracture prevention.
	2.5 MHAS	27 All funded MHAS will screen for mental health, addictions and physical health issues, and promote healthy lifestyles.
	2.8.1 Diabetes	5 Ensure primary care continues to target at-risk populations to perform checks for diabetes in Maori patients and achieve 90% checks in this high-risk group. 6 Continue to deliver the "Stop Gout" programme in partnership with community pharmacies in Northland which currently targets Maori patients, and where possible expand the programme.
	2.8.3 Cardiac services	9 Implement the redesigned cardiac rehabilitation/ high risk prevention programme, targeting those most at risk, reducing the burden of heart disease in Northland communities by improving the equitable uptake of lifelong heart modification and lifestyle changes.

2.1.3 High value and performance

Theme components	Annual Plan section and action	
Focus on outcomes: people's experience of care, health and equity of health outcomes, and best-value use of resources	2.14 Living within our means	*All 9 actions.* *[Equity is mainly addressed under the fourth component of this section.]*
Transparent use of information to drive learning and decision-making for better performance	2.5 MHAS	9 Embed the RBA contracting framework for MHA services with NGOs using an outcomes focused approach, aligned with the MoH commissioning and outcomes framework. 36 Increase the use of evidence informed group work across Mental Health and Addiction Services. 46 Establish NGO RBA reporting dashboards to measure service outcomes and improve service performance. 50 Northland DHB will establish a secure reporting database (including RBA and PRIMHD) reporting to allow across-sector data analysis for strategic and operational planning.
	2.8.1 Diabetes	5 Monitor and provide feedback on current medical management of diabetes against best practice guidelines including triple therapy, prescribing of statins and ACE inhibitors, recognition and treatment of chronic renal disease.
	2.8.3 Cardiac services	3 Review and audit Accelerated Chest Pain Pathways (ACPPs) in Emergency Departments by end of Q2.
	2.9 Whanau Ora	2 Regularly communicate at a regional level through the Regional GM Maori network and Tumu Whakarae Engage with appropriate agencies to identify opportunities to support Whanau Ora providers and collectives in Te Tai Tokerau by strengthening Maori workforce capability and capacity, including Maori in health planning and using supporting data on needs and service utilisation in service delivery and design. Support agreed joint initiatives to galvanise collective impact to support the achievement of outcomes for whanau. 7 Ethnicity data analysis of the five key WO areas will be provided to NDHB Executive Leadership Team to address ongoing inequities.
Strong performance measurement and a culture of improvement, in which we are open and honest about where we can improve	2.2.1 – 2.2.6	*All Health Targets*
	Module 7	*All quarterly performance measures*
	2.2.1 Shorter stays in EDs	1 Complete the implementation of and monitor the MoH's "A Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care" to including the capability to monitor all measures and identify and address opportunities for improvement in response to the framework's findings. 6 Review processes for acute surgical and orthopaedic patients presenting to ED with a view to reducing avoidable admissions and streamlining admissions for some patient groups as appropriate.
	2.2.2 Improved access to elective surgery	1 Reduce and maintain the waiting times for FSAs in surgery and diagnostics.
	2.4.2 HOP interRAI	2 Northland DHB NASC to continue to carry out InterRAI Home Care and Contact assessments in order to meet Ministry requirements
	2.5 MHAS	5 Review the MHAS clinical governance structure to strengthen the clinical and management partnership, so that it promotes the best possible service quality, service user experience and service performance. 6 Review the MHAS quality improvement and innovation group to ensure a sound quality assurance programme is in place, and that there are focused service improvement activities that change and improve service quality, safety and performance. 18 Implement interventions that will upskill mental health and addiction

Theme components	Annual Plan section and action	
		nurses in physical health assessment, building on the successful pilot completed in the Far North in 2015. 37 Measure outcomes by implementing HoNoS, alcohol and other drugs outcome measure (ADOM) and the Real Time Consumer Feedback process, and initiate a codesign approach to service improvement.
Striving for equity of health outcomes for all New Zealand populations	2.2.3 Faster cancer treatment	9 Ensure DHB Cancer Care Coordinators work closely with the Cancer Navigator in cancer care for Maori patients (report in Q3). 14 Implement initiatives to work towards equitable screening rates for Maori women for breast cancer (with the breastscreening service which is run in partnership with WDHB) and cervical screening (with the Northland PHOs). 15 Work with NRA to review current regional cancer equity reporting and create a plan for developing robust regional equity goals in partnership with clinicians.
	2.2.4 Increased immunisation	4 Monitor ongoing earlier referrals to outreach services for children at 5 months, 2 weeks of age in specific Maori children to support timely vaccination of six month event and equity of six month rate for Maori. Increase six month rate to 80% by December 2016. 6 Routine analysis of data by ethnicity, deprivation, age, gender and location. 7 Continue ongoing work with Maori providers to support track and tracing of individual children and co-visiting where relevant for outreach Immunisation. Explore opportunities to work with Maori providers to focus specifically on Maori whanau declining immunisations; engage with providers by June 2016.
	2.2.5 Better help for smokers to quit	*Maori whanau specific actions 3 – 7 and 13.*
	2.2.6 Childhood obesity	5 Continue to engage with Northland ALT to ensure that resources are dedicated to the identification and provision of services to Maori tamariki that have been identified as overweight or obese through B4SC.
	2.2.3 FCT	2 Primary care will continue work with the National Cervical Screening Programme on data quality, including ethnicity data, to improve invitation and recall processes, and to ensure a quality screening service for Maori women. 9 Ensure DHB Cancer Care Coordinators work closely with the Cancer Navigator in cancer care for Maori patients (report in Q3).
	2.2.6 Childhood obesity	3 Ensure that the service provider is delivering culturally appropriate interventions to tamariki Maori and whanau, maximising engagement and outcomes through development of appropriate feedback mechanisms and case studies highlighting individual successes. 4 Working with stakeholders across Northland – the lead provider will focus on supporting iwi providers, to enable children living in high deprivation areas to access programmes by working with the lead provider to establish rollout of the new programme, prioritising areas of high deprivation and access to Maori tamariki.
	2.4.4 HOP Dementia Care Pathway	5 Further engagement with Maori whanau to support ongoing review, design and implementation of support for Maori.
	2.5 MHAS	12 Implement the 'working with Maori' enabler from the Let's Get Real framework, using outcomes from the 'Working with Maori' Hui in August 2015, in partnership with Te Poutokomanawa and other key stakeholders. 13 As part of the 'working with Maori' enabler action, evaluate the Maori clinical service model (Te Roopu Whitiora) and implement a 'kaupapa Maori' MHA service model.

Theme components	Annual Plan section and action	
	2.6.1 Maternal & child health	7 Model of care seeks to reorient and enhance health and social service support services to better meet the needs of pregnant and postnatal Maori women experiencing adversities. 9 Improve access to antenatal education/parenting preparation for Maori woman and whanau through adaptation and delivery of the Te Mata O Mua Kaupapa Maori antenatal programme to rural communities.
	2.7 Youth health	9 Focus our efforts on decile 1-3 high schools and colleges as they have the highest Maori rolls.
	2.8.1 Diabetes	2 In line with Standard 4 of the 'Quality Standards of Diabetes Care Toolkit, design, develop and deliver a project to identify and provide support to individuals with poorly controlled diabetes (HbA1c over 64mmol or with existing complications) and low to moderate mental health issues and provide them with additional support. Services and funding will be focused on Maori patients and whanau to support the reduction of health inequities experienced by Maori with diabetes. 3 Refocus funding for the Green Prescription (GRx) service to incentivise Maori referrals, increasing access to the programme and reducing health inequities for Maori. Funding will incentivise the provider to increase the ratio of Maori referrals by 10% this year (to achieve a target of 51.9% Maori) which will require an increase in Maori numbers by 41% to achieve the target. 7 Continuously evaluate, develop and promote patient self-management programmes, ensuring that these are accessible and culturally appropriate to Maori patients.
	2.8.2 CVD	2 Continue to proactively identify and offer to eligible Maori men between 35-44 years a CVD risk assessment. 3 Subject to funding, invest and increase the resources of Northland's Primary Options service to provide additional interventions to CVD patients so that they can receive treatment closer to home; within Primary Options, target Maori patients. 5 Continue to fully utilise the Green Prescriptions volumes, ensuring that they are culturally accessible for Maori, achieving a 10% increase in Maori participants.
	2.8.3 Cardiac services	10 Review, audit and develop strategies to improve access for Maori and other high risk groups. This includes more effective use of available data within the ANZACS-QI database.
	2.9 Whanau Ora	*All 8 actions.*
	2.13 Quality and safety	7 Improve ethnicity data collection in patient surveys.
An integrated operating model that makes people's responsibilities clear	2.2.4 Increased immunisation	2 Continued monitoring of individual children to result in timely vaccination utilising the newly implemented monitoring tool, inclusive of 8-month, 2-year-old and 5-year-old children.
	2.2.5 Better help for smokers to quit	8 Monitor smoking status at time of confirmation of pregnancy or booking with a Lead Maternity Carer, and offer brief advice with an emphasis on support and/or referral to stop smoking service providers. 18 Through education and direct referrals, increase the number of pregnant women who are referred by DHB Maternity Services to Stop Smoking Services and women who have given birth to prevent relapse or support quit post-delivery. 21 The Smokefree team will raise awareness within the community of the Government's smokefree 2025 goal with a focus on increasing support for, and actions towards, this goal within the community.
	2.8.1 Diabetes	4 Implement systems and processes to identify prediabetes in at-risk groups and initiate plans for early intervention, ensuring community programmes are available across Northland to provide appropriate support in key areas such as management of obesity, nutritional

Theme components	Annual Plan section and action	
		advice and support with physical activity (Green Prescriptions). 9 Continuously evaluate, develop and promote patient self-management programmes, ensuring that these are accessible and culturally appropriate to Maori patients.
	2.8.2 CVD	5 Continue to fully utilise the Green Prescriptions volumes, ensuring that they are culturally accessible for Maori, achieving a 10% increase in Maori participants. 6 Continue to deliver and expand where possible kaupapa Maori self-management modules for disease-specific education.
	2.9 Whanau Ora	6 Te Roopu Kai Hapai Oranga (Northland Alliance Leadership Team) commit to collective decisions to dedicate resources and effort to Maori whanau in: • reducing smoking rates • improving healthy lifestyles initiatives (obesity). • asthma care planning in primary care • Maori children receiving quality B4 school checks • reducing the rate of Maori committed to community treatment orders
The use of investment approaches to address complex health and social issues	2.3.2 Neighbour-hood Healthcare Homes	1 In collaboration with the two PHOs support for up to 8 practices/ networks to develop into NHHs.
	2.3.1 Fit for Life - obesity	*Actions 1-4 re developing initiative, funding and recruitment.*
	2.3.8 Rural SLAT	3 Invest in a service that meets the current needs of the primary care multidisciplinary workforce; that builds capacity to delivery changes in models of care that allow care closer to home; and provides for a vibrant and sustainable future workforce in Northland.
	2.6.2 Rheumatic fever	2 Provide funding investment for Rheumatic Fever prevention from July 2017 and provide an investment plan in quarter 2.
	2.17 Inter-sectoral action	*All 8 actions.*

2.1.4 One team

Theme components[1]	Annual Plan section and action	
Operating as a team in a high-trust system with better cohesion *[The actions under the first component under 2.1.2 also apply here.]*	2.2.2 Improved access to elective surgery	4 Continue to work with primary care to improve patient pathways and support the management of care in the community.
	2.3.3 Primary Options	*(Four actions focused on Maori and high needs populations.)*
Making the best, most flexible use of our health and disability workforce	2.3.3 Primary Options	2 Workforce development of primary care nurses and general practitioners: • IV cannulation and therapy designations • provide ongoing education/information on all new pathways across Northland. • diagnostics • working collaboratively with hospital specialist teams
	2.3.5 Mental Health Stepped Care Model	1 The workforce across the care continuum will receive training in the Stepped Care Model to develop confidence and competence in the area of care relevant to their specific scope of practice. Shared training will be key to improving understanding of the respective roles of the primary and secondary services.
	2.3.8 Rural	3 Invest in a service that meets the current needs of the primary care

[1] Two of this theme's components, "the system leadership role of MoH" and "collaborating with researchers" are not relevant to Northland DHB.

Theme components[1]	Annual Plan section and action	
	SLAT	multidisciplinary workforce; that builds capacity to delivery changes in models of care that allow care closer to home; and provides for a vibrant and sustainable future workforce in Northland.
	2.5 MHAS	8 Establish a MHA services workforce development plan aligned with the five year strategic plan and vision. 16 Workforce development planning will address co-existing problem (CEP) capability across the sector
	2.7 Youth health	14 Establish a workforce development plan to increase the number of clinicians in Northland who are undertaking or working towards a qualification in youth health and development. 22 Enhanced Co-existing Problem (CEP) services within Whangarei-Kaipara and Far North through partnership between NGOs and NDHB; this includes capacity to address physical health issues.
	2.8.2 Cardiac services	8 Implement changes following a Northland DHB external cardiology review which include workforce development, expanding nurse-led initiatives, cardiology ambulatory services improvement programme and demand and capacity planning.
	2.9 Whanau Ora	2 Regularly communicate at a regional level through the Regional GM Maori network and Tumu Whakarae Engage with appropriate agencies to identify opportunities to support Whanau Ora providers and collectives in Te Tai Tokerau by strengthening Maori workforce capability and capacity, including Maori in health planning and using supporting data on needs and service utilisation in service delivery and design. Support agreed joint initiatives to galvanise collective impact to support the achievement of outcomes for whanau. 5 Ensure Maori health care workforce are accessing the HWNZ non-regulated workforce training fund to build capability and capacity.
Leadership, talent and workforce development throughout the system	2.2.3 FCT	1 Support NDHB involvement in a regional nurse endoscopist training programme. 13 Cancer care coordinators will participate in regional and national training sessions on an ongoing basis.
	2.2.5 Better help for smokers to quit	11 General practice nurses who want to provide dedicated stop-smoking services will be encouraged to undertake the necessary training (National Stop Smoking Practitioners Programme) to provide better help for smokers to quit.
	2.3.5 Mental Health Stepped Care Project	4 The requirement for the service to be provided by 'suitably qualified health practitioners' will be audited and documented.
	2.7 Youth health	14 Establish a workforce development plan to increase the number of clinicians in Northland who are undertaking or working towards a qualification in youth health and development.
	2.9 Whanau Ora	5 Ensure Maori health care workforce are accessing the HWNZ non-regulated workforce training fund to build capability and capacity.
Strengthening the roles of people, families, whānau and communities as carers	2.4.1 HOP system integration	3 Establish a programme for GNSs to provide ACP with community clients.
	2.4.4 HOP Dementia Care Pathway	2 Provide detailed information of dementia education and support programmes in operation to support informal carers and people living with dementia (as per the NRHP) engaging with consumers and whanau to assess equity of access by ethnicity, locality, source, acceptability, variability and sustainability.
	2.5 MHAS	1 Create a five-year MHAS strategic plan outlining the future vision and how this will be achieved, with active involvement and participation by staff, service users, family and whanau, NGOs, primary care and other key service stakeholders. 28 All service users and families will be provided with information about mental illness and addictions, MHA services, and health and wellbeing.

Theme components[1]	Annual Plan section and action	
	2.6.1 Maternal and child health	17 Enhance and expand culturally competent service delivery models that best support families with children who are overweight or obese at B4SC toward a healthy weight

2.1.5 Smart system

Theme components	Annual Plan section and action	
Information being reliable, accurate and available at the point of care	2.3.6 Care Connect	*5 actions about implementing " the beginning of an electronic health record [to] enable clinical partnerships that span across the health continuum and ensure the right information is available at the right time by the right provider" .*
	2.4.1 HOP system integration	4 Work in partnership with GPs in ARRC to implement timely responses to integrated laboratory information and results.
	2.6.1 Maternal & child health	10 Continue the current programme of systems and process improvement in newborn integrated enrolment and completion of NBHS screening, immunisation, core well child contacts 1-3 and oral health service enrolment and assessment.
	2.15 Info technology	*All 11 actions.*
Individual online health records that people are able to access and contribute to	2.5 MHAS	42 Establish a rationalisation of reporting project to reduce duplication by establishing one single care plan for each service user.
	2.3.6 Care Connect	*5 actions about implementing " the beginning of an electronic health record [to] enable clinical partnerships that span across the health continuum and ensure the right information is available at the right time by the right provider" .*
Data and smart information systems that improve evidence-based decisions, management reporting and clinical audit	2.3.6 Care Connect	*5 actions about implementing " the beginning of an electronic health record [to] enable clinical partnerships that span across the health continuum and ensure the right information is available at the right time by the right provider" .*
	2.5 MHAS	43 Implement a clinical dashboard reporting system to provide meaningful data that informs clinical decision making, and more efficient and effective ways of working. 44 Establish NGO RBA reporting dashboards to improve service performance.
	2.8.3 Cardiac services	3 Review and audit Accelerated Chest Pain Pathways (ACPPs) in Emergency Departments.
		10 Review, audit and develop strategies to improve access for Maori and other high risk groups. This includes more effective use of available data within the ANZACS-QI database.
Standardised technology that allows us to easily make efficient changes	2.3.6 Care Connect	*5 actions about implementing " the beginning of an electronic health record [to] enable clinical partnerships that span across the health continuum and ensure the right information is available at the right time by the right provider" .*
	2.4.2 HOP interRAI	4 Continue to develop an automated solution for reporting time taken from any referral source to completion of an interRAI assessment, comparing performance with Northern Region DHBs.
Being able to take advantage of opportunities of new and emerging technologies	2.2.4 Increased immunisation	1 Explore further options for social media to inform and remind.
	2.3.4 Telehealth	*[6 actions re growing telehealth services throughout Northland and across the Northern Region.]*
	2.6.1 Maternal & child health	5 Investigate the added value of smartphone technology to increase access to information to young parents.
	2.7 Youth health	12 Public Health Nurses will transition from a paper-based PMS to an electronic record that is aligned with primary care.

2.1.6 Four particular priorities

Particular priorities in the NZ Health Strategy are obesity, long term conditions, service configuration and information technology. Northland DHB's Annual Plan addresses each of these in the following manner:

Obesity

2.2.6 Childhood obesity addresses the new obesity Health Target that is centred on B4 School Checks.

2.3.1 NHSP Fit for Life – obesity describes how we are aiming to increase the number of tamariki who are at a healthy weight in Tai Tokerau by:

- building an integrated community-wide response
- starting a shift toward healthy food becoming more desirable, accessible and affordable
- allowing coordinated work across multiple levels in the food system to help create an environment that supports healthier eating.

Long term conditions

2.8 Long term conditions describes our activity across diabetes, cardiovascular disease, acute heart health and stroke; 2.2.3 Faster cancer treatment is also relevant under the LTC umbrella.

2.5 Mental Health and Addictions Services, as well as dealing with mental health issues that are prevalent in our community, also includes an action: "All funded MHAS will screen for mental health, addictions and physical health issues, and promote healthy lifestyles". 2.3.5 The Mental Health Stepped Care Model "aims to improve the experience of patients with mental health issues by… increasing timely access to organised mental health and addiction responses at the most appropriate level across primary and secondary care".

2.3.7 Community pharmacy aims to "develop and promote pharmacists working to the top of their scope, offering additional services to patients that add value to health outcomes". The section mentions tobacco and sexual health specifically, but also aims to "identify further opportunities for pharmacies to offer treatment, health literacy and services to patients closer to home that will contribute to the goal of eliminating health inequalities for Maori" that is congruent with a focus on managing long term conditions.

The key driver for 2.3.4 Telehealth is to "deliver health services closer to home for patients with benefits such as less travel, cost and fewer hospital touch points such outpatient clinic visits", thus increasing the amount and timeliness of contact between people with LTCs and clinical staff to enhance management of conditions.

Service configuration

2.3 System integration highlights eight areas in which Northland is working on integrating services across the health sector. Four of them have already been mentioned above (Fit for Life Obesity, Telehealth, the Mental Health Stepped Care Model, Community Pharmacy), and there are also:

- 2.3.2 NHSP Neighbourhood Healthcare Homes is a key building block for the way forward in Northland. It is "a team-based and locality-networked primary healthcare delivery model led by primary care clinicians that provides comprehensive and continuous health and social care, with the goal of supporting individuals toward better health outcomes. It is a fully integrated, multidisciplinary team of providers. It is accountable for the health and wellness of its enrolled population and ensuring equitable access to its services for enrolled patients. It is the hub that delivers and coordinates high quality, equitable healthcare"
- the goals of 2.3.3 Primary Options are "to reduce referrals and hospital admissions through the provision of an appropriate range of services in the primary care setting, and to facilitate early and effective discharge from hospital into primary care through avoiding escalation of care to reduce ED presentations"
- 2.3.6 Care Connect is a regional initiative "to improve information sharing among community and hospital healthcare providers for the benefit of patients" that will "facilitate the beginning of an electronic health care record, enable clinical partnerships that span across the health continuum and ensure the right information is available at the right time by the right provider"
- 2.3.8 Rural Service Level Alliance Team (SLAT) aims to achieve "accessible primary care for Northlanders in rural areas out of hours; a multi-skilled and sustainable workforce in rural Northland that is able to meet the needs of patients; models of care which provide services to patients closer to home". Over half (92,000) of

Northland's population is enrolled outside Whangarei practices and many rural communities are deprived, so it is important to consider cost of and distance to out-of-hours services.

Information technology

2.15 Information technology describes plans to work towards care that is integrated care and closer to home. An IT infrastructure that supports right place right time clinical decision-making and enables responsiveness to change will enable limited health resources to be focused on planning and providing care, and make access to the right care quicker and safer.

2.2 Health Targets

NRHP Our intervention logic and regional targets \ National Health Targets

2.2.1 Shorter stays in Emergency Departments (EDs)

NRHP 4 Our Intervention Logic and Regional Targets, National Health Targets
Top 19 priorities, no. 1

What outcomes are we trying to achieve?

Northland DHB wants to deliver high quality emergency and acute care to the population of Northland. Achieving the Shorter Stays in ED Health Target is the mechanism by which the quality of DHB emergency and acute care systems is measured.

Why is this important for community and patients?

Our standard of care should be the highest possible and exceed the expectations of patients and whanau. Valuing our patients' time and ensuring the provision of safe, good quality, effective, efficient and timely care are key to achieving this standard.

It is widely accepted that long stays in emergency departments are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Whangarei Hospital does not have an acute assessment and planning unit which is considered an essential element of an acute medical patient journey and would greatly assist to decompress the ED. Planning to build such a unit is underway, however, in the absence of a unit Whangarei Hospital will struggle to consistently meet the Shorter Stays in Emergency Departments Health Target. In the intervening period the focus will be on striving to achieve some of the benefits a unit will bring such as improved access to acute specialists, reduced avoidable admissions and improved flow of acute patients. Our analysis identifies the following actions as key to this, and to improving our target performance.

Actions planned for 2016/17

Under the guidance of the Whangarei Hospital Urgent Care Governance Group:

1 Complete the implementation of the MoH "A Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care" including the capability to monitor all measures and identify and address opportunities for improvement in response to the framework's findings.

2 Establish acute medical clinics to provide primary care with an alternative for referral of acute patients where appropriate.

3 Establish a nurse-led acute patient flow forum to drive an across-hospital system of care which supports the acute medical patient pathway. Senior nurses have the opportunity to lead transformation efforts to achieve the improvement change required.

4 Improve the alignment of Acute Medicine SMO and RMO support with the capacity required in emergency and acute care with a particular emphasis on daily and seasonal periods of peak demand. This includes reducing the reliance on locums to enable better alignment of process..

5 Establish rapid response community follow-up for selected groups of patients to support discharge from Whangarei Hospital's Emergency Department and avoid unnecessary admission.

6 Review processes for acute surgical and orthopaedic patients presenting to ED with a view to reducing avoidable admissions and streamlining admissions for some patient groups as appropriate by end of Q1.

7 Continue to progress through the stages of the Government's Better Business Cases process to achieve the required approvals for a new purpose-built Emergency Department and Acute Assessment Unit at Whangarei Hospital.

Measuring and monitoring performance

95% of patients will be admitted, discharged or transferred from the Emergency Department within 6 hours with Health Target reporting by ethnicity.

By 30 September 2016 acute clinics are established and routinely rostered.

By 30 September 2016 nurse-led acute patient flow accountability is established, key measures identified and monitored, and service and process improvements initiated in response to the findings.

By 30 June 2017 the alignment of Acute Medicine SMO and RMO support with the capacity required in emergency and acute care is increased.

By 30 June 2017 a rapid response community follow-up service for selected groups of patients discharged from ED is established.

Pending Capital Investment Committee approval of the Strategic Assessment Business Case, the timeline for the development of the Indicative Business Case for the ED/AAU will be met.

2.2.2 Improved access to elective surgery

NRHP 4 Our Intervention Logic and Regional Targets, National Health Targets
4 Key service delivery areas \ Other services – elective services

What outcomes are we trying to achieve?

Through the promotion and support of clinical leadership NDHB will provide timely and equitable access to elective surgery to improve the health outcomes for the community we serve.

Why is this important for community and patients?

The Northland community is widely geographically spread and has a high level of deprivation which poses specific and unique challenges in providing accessible services. Patients and their referrers must be sure of the steps to access elective surgery and know that they will have timely access to assessment, diagnostic and treatment services. Our community must have trust and confidence that the process is fair and that their DHB is working efficiently and effectively to serve the community of which they are a part.

Actions planned for 2016/17

1 Reduce and maintain the waiting times for FSAs in surgery and diagnostics (2.12 Diagnostic waiting times). NDHB offers continued contribution into the formal regional service review programme which includes elective surgery and its supporting diagnostic services.

2 Increase use of the regional operating facility in Kaitaia.

3 Reduce DNA rates in our community through the identification and implementation of a patient-centred approach to booking. Recent approval of funding will enable us to proceed with review and implementation of patient centred booking process in clinics.

4 Continue to work with primary care to improve patient pathways and support the management of care in the community.

5 Continue to work towards implementing National Patient Flow concepts in line with Ministry objectives.

6 Implement new national Orthopaedic scoring tool.

7 Continue to work with Waitemata DHB in the delivery of bariatric surgery to our community.

8 Continue to work with the region in the development of a patient pathway for Northland patients requiring complex upper GI surgery.

9 ESPI 1 compliance will continue to be maintained. Weekly monitoring of ESPI 1 performance will continue.

10 Deliver to our agreed electives schedule as monitored weekly by the DHB and monthly by the Ministry.

11 As the Ministry of Health updates nationally developed and standardised clinical prioritisation tools, NDHB will transition departments to these as they arise.

12 Treat patients in accordance with their assigned priority and waiting times, and prioritise the identification of improvements to sustain service improvements in accordance with this.

13 Expand the capacity and resource to manage the growing requirement to treat macular degeneration in our community.

14 Work with ED to review processes for acute surgical and orthopaedic patients presenting to ED (2.2.1 Shorter stays in EDs action 6).

Measuring and monitoring performance

8,575 elective surgical discharges (6,658 base and 1,917 additional), comprising 8,275 from last year (6,550 base plus 1,725 electives initiative) and 300 new for 2016/17. There is further funding available for 130 discharges specifically for General Surgery, Major Joints and non-joint Orthopaedics, meaning a potential total of 8,705 elective discharges..

NDHB will monitor electives compliance to ESPI 2 and ESPI 5 and prioritise service improvements to sustain compliance to ESPI wait times.

NDHB will deliver to our agreed electives schedule as monitored weekly by the DHB and monthly by the Ministry.

Weekly monitoring of ESPI 1 performance will continue.

2.2.3 Faster cancer treatment

↪ NRHP 4 Our Intervention Logic and Regional Targets, National Health Targets
Top 19 priorities, nos. 4, 5
4 Key service delivery areas \ Cancer services

What outcomes are we trying to achieve?

Encourage and help our population to adopt healthy lifestyles that minimise the risk of developing cancer, particularly smoking cessation (2.2.5 Better help for smokers to quit) and moderate alcohol use. We coordinate the delivery of breast and cervical screening programmes to detect cancer at an early stage when it can be cured or ameliorated.

Improve equity by ensuring Maori women within the priority group (aged 25-69 years) are provided with a cervical screening event within the last 3 years.

We will continue to improve the organisation and systematisation of services across tumour stream pathways to reduce cancer morbidity and mortality.

We will continue to take a tumour stream, whole-of-systems focus.

We also work regionally to ensure our compliance with nominated national tumour standards, and to implement prioritised improvements where these are required.

We are committed to working regionally to improve coordination of care and establishing standardised cancer pathways where possible as detailed in the Northern Region Cancer network Strategic Plan 2014/15 to 2019/20.

Success in these endeavours will mean longer lives free of cancer.

Why is this important for community and patients?

In New Zealand, cancer ranks alongside cardiovascular disease as a leading cause of death, currently accounting for almost one-third of all deaths.

There are inequalities in cancer outcomes. The burden of cancer – especially tobacco-related cancer – falls disproportionately on Maori and on socioeconomically disadvantaged individuals, families and communities, thus contributing to health inequities.

Northland DHB has a higher proportion of older (45-64 and 65+) people (47%) than the Northern Region (36%) and nationally (41%). We also have a higher proportion of Maori (30%) than the regional (12%) and national (14%) populations.

In Northland the age-standardised rate of cancer registrations 2010-2012 was 342 per 100,000, higher than the Northern Region (Waitemata 327, Auckland 331, Counties Manukau 331) and New Zealand (338).

In Northland the age-standardised rate of cancer mortality 2010-2012 was 143 per 100,000, higher than the Northern Region (Waitemata 113, Auckland 113, Counties Manukau 128) and New Zealand (126).

Despite significant improvement in recent years, some of our patients still wait too long for their cancer diagnosis and treatment, and some struggle to navigate their way through our health services, causing unnecessary suffering and stress for both patients and their family/whanau.

Actions planned for 2016/17

1 Support NDHB involvement in a regional nurse endoscopist training programme.

2 Primary care will continue work with the National Cervical Screening Programme on data quality, including ethnicity data, to improve invitation and recall processes, and to ensure a quality screening service for Maori women. Referral processes to colposcopy services will be refined. Work with the National Cervical Screening Programme to identify opportunities for incentivising Maori women who have lapsed history presenting for a smear. Continue with data matching for unscreened and underscreened Maori women.

3 Achieve the 62-day treatment target for cancer services by 30 June 2016.

4 Undertake tumour stream-focused improvements based on identified barriers in the pathway for meeting the 62 day indicator. Lung Cancer improvements report end of Q2.

5 Improve quality of services by reviewing current service delivery against provisional tumour standards (2 standards to be reviewed) and identifying and implementing service improvement plans, including streamlining diagnostic and treatment processes.

6 Actively participate in the regional tumour stream activities facilitated by the Northern Cancer Network (NCN) (ongoing, report in Q2).

7 Provide quarterly reports on the cancer indicators and Health Targets (in progress and ongoing).

8 Continue to achieve the four-week waiting time target for radiotherapy and chemotherapy (old Health Target).

9 Ensure DHB Cancer Care Coordinators work closely with the Cancer Navigator in cancer care for Maori patients (report in Q3).

10 MDM meetings will be highly functional both locally and regionally using regionally agreed tumour stream templates.

11 Implement additional regional MDMs as these are finalised.

12 Cancer care coordinators will participate in regional and national training sessions on an ongoing basis (in progress on-going).

13 Implement supportive care initiatives.

14 Implement initiatives to work towards equitable screening rates for Maori women for breast cancer (with the breastscreening service which is run in partnership with Waitemata DHB) and cervical screening (with the Northland PHOs).

15 Work with NRA to review current regional cancer equity reporting and create a plan for developing robust regional equity goals in partnership with clinicians.

16 Implement the recommendations of the *Prostate Cancer Awareness and Quality Improvement Programme* report.

Measuring and monitoring performance

80% coverage for Maori women to be screened for cervical cancer in the past 36 months.

Continued compliance with PP30(b), the cancer target of maximum four weeks waiting time for radiotherapy and chemotherapy.

Faster cancer treatment indicators will be routinely measured and reported quarterly and monthly:

FCT Health Target: by July 2016 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks, and increasing to 90% by 2017/18 Q1.

PP30(a), the 31 day indicator: the length of time taken for patients to receive their first treatment (or other management) for cancer from date of decision-to-treat.

Report on the tumour streams using the regionally agreed templates in MDM meetings.

Cancer mortality rates will reduce and ethnic differences in outcomes will reduce.

Breastscreening target 70%; cervical screening target 75%.

2.2.4 Increased immunisation

NRHP 4 Our Intervention Logic and Regional Targets, National Health Targets

What outcomes are we trying to achieve?

Improve the health and wellbeing of all children in Northland through achieving the Immunisation Health Target of 95% of children fully immunised Maori and Non-Maori at 8 months, 2 years and 90% at 5yrs. 70% of girls aged 11-12 will have completed dose one of HPV in School Based Programme.

Why is this important for community and patients?

Timely Immunisation protects our community and tamariki from preventable diseases. Focus is taken to ensure Maori infants have equitable access to timely immunisation as Maori children in Northland experience poorer health outcomes.

Actions planned for 2016/17

1 Continued implementation of the NDHB Communication Strategy for consistent key messages across Northland. Explore further options for social media to inform and remind for timely immunisation.

2 Continued monitoring of individual children to result in timely vaccination utilising the newly implemented monitoring tool, inclusive of 8-month, 2-year-old and 5-year-old children.

3 Monitor ongoing earlier referrals to outreach services for children at 5 months, 2 weeks of age in specific Maori children to support timely vaccination of six month event and equity of six month rate for Maori. Increase six month rate to 80% by December 2016.

4 Outreach services to be responsive; through the Immunisation Coordinator coordinating staff to ensure vaccination outcomes for priority target children across all of Northland(ongoing).

5 Robust analysis of data to inform strategic direction.

6 Routine analysis of data by ethnicity, deprivation, age, gender and location.

7 Continue ongoing work with Maori providers to support track and tracing of individual children and co-visiting where relevant for outreach Immunisation. Explore opportunities to work with Maori providers to focus specifically on Maori whanau declining immunisations; engage with providers by June 2016.

8 Continue implementation of NDHB education plan by focusing on increasing health literacy for health professionals (inclusive of allied health). Co-joined education forums facilitated and supported by NDHB to include Well Child Tamariki Ora providers, secondary care, primary care and Maori providers, by quarter 2.

9 Monitor and increase the four year old milestone, by quarter 3.

10 Continue implementation of and support the School Based Vaccination team to increase HPV (12 year old) immunisation rates.

11 Continue opportunistic Immunisation with Secondary Services and other NDHB providers including Oral Health (Surgical Bus in two communities in Northland).

12 Maintain Steering Group to provide governance and monitoring to ensure target levels of Immunisation are met and equity is addressed.

Measuring and monitoring performance

95% of 8-month old children are fully immunised by June 2016 and maintained.

80% of 6-month immunisations are completed by December 2016 and maintained.

95% of 2-year immunisations are completed and maintained by June 2016.

2.2.5 Better help for smokers to quit

NRHP 4 Our Intervention Logic and Regional Targets, National Health Targets

What outcomes are we trying to achieve?

Eliminate inequities between Maori and non-Maori smoking rates in Tai Tokerau and increase the life expectancy of Maori in Northland.

1,000 successful quits by Maori every year for the next 10 years.

We want to make progress towards the national "Smokefree Aotearoa by 2025" target and implement the *Tupeka Kore Te Tai Tokerau 2025 Strategic Plan 2015-18* so that there are less than 5% Maori smokers in Northland.

We want to reduce the harm caused to Maori whanau and environments from tobacco use and secondhand smoke. We will do this through effective health promotion, prevention and stop-smoking services, particularly focused on Maori whanau, pregnant Maori women Maori mental health service consumers and Maori youth.

Why is this important for community and patients?

Tobacco smoking is the main cause of preventable morbidity and premature death in New Zealand, particularly so in Northland where Maori smoking rates are higher than the national average. Smoking causes a wide range of diseases including cancers, cardiovascular disease and respiratory disease. It also causes complications in pregnancy, including risk of premature birth and low birth weight and sudden unexpected death in infancy (SUDI).

Northland children as young as 11 take their first puff on a cigarette. 9.4% of Northland students smoke regularly compared to 7.7% of students nationally. Research shows that nicotine makes tobacco products highly addictive, and young smokers can show signs of addiction after only one cigarette.

Northland hospitalisation data for 2014/15 showed that 21% of the inpatients were current smokers but Maori had a higher (38%) rate than Non-Maori (14%).

The prevalence of smokers in Northland is 19.1% (NZ 15.1%). 33.9% of Northland Maori (nationally 32.7%) and 28.6% of Pacific peoples (nationally 23.2%) smoke regularly; both have higher smoking rates than other ethnicities.

42.8% of pregnant Maori women smoke in Northland with subsequent increased rates of SUDI and other health morbidities.

Actions planned for 2016/17

1 Meet better help for smokers to quit Health Targets and other quarterly reporting measures:
- 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
- 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking
- 95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.

2 Reconfigure tobacco control services and resources to better meet the need of our priority groups (defined by population, geography and evidence).

Initiatives led by Maori and/or community organisations

Maori whanau specific:

3 Stop smoking teams will offer support and treatment to all Maori who smoke.

4 Ensure promotional presence at events where Maori whanau who smoke are likely to attend (sports events, festivals, Waitangi Day etc).

5 Apply Group Based Therapy and initiatives such as incentivising mechanisms in WERO or with pregnant women who smoke.

6 Improve referral processes with midwives and Lead Maternity Carers and Stop Smoking Services to support more hapu mama who smoke to quit.

7 Ensure Stop Smoking Service practitioners undertake the necessary training (National Stop Smoking Practitioners Programme) as soon as new realigned services are contracted for.

Initiatives led by primary care

General practice:

8 Monitor smoking status at time of confirmation of pregnancy or booking with a Lead Maternity Carer, and offer brief advice with an emphasis on support and/or referral to stop smoking service providers.

9 Fund free stop-smoking support in general practices (all practices are allocated a certain number of free packages based on their high need smoking population).

10 Bulk NRT routinely supplied to practices.

11 General practice nurses who want to provide dedicated stop-smoking services will be encouraged to undertake the necessary training (National Stop Smoking Practitioners Programme) to provide better help for smokers to quit.

Maternity specific:

12 Apply success factors of smoking pregnant women incentive pilot in Kaikohe/ Kaitaia to other high needs areas for Maori such as Hokianga, Whangarei, Kaipara.

13 Improve the referral process for midwives and Lead Maternity Carers to support more hapu mama who smoke to quit.

14 Encourage midwives to participate in smoking cessation training specific to pregnant women who smoke.

Initiatives led by secondary care

Departments, wards and clinics:

15 To increase the number of cessation referrals, staff training on the ABC of smoking cessation will focus on all DHB outpatient departments community clinics and services.

16 To increase the number of supported quit attempts and support the realignment of Stop Smoking Services, all hospitals and DHB community services cessation referrals will be made directly to Stop Smoking Services.

Mental health specific

17 Through audits and feedback, monitor the compliance to smokefree policy and withdrawal management and treatment of smoking of Mental Health Services users in their journey from admission and discharge from Tumanako (mental health inpatient unit) and the Subacute Units.

Maternity specific:

18 Through education and direct referrals, increase the number of pregnant women who are referred by DHB Maternity Services to Stop Smoking Services and women who have given birth to prevent relapse or support quit post-delivery.

19 Build relationships with midwives and Lead Maternity Carers to enable referral process and support to quit for hapu mama who smoke.

Initiatives led by Public and Population Health

Health Promotion:

20 The Public Health Unit will develop a district-wide tobacco control communication strategy for 2016/17 in collaboration with all stop smoking services, PHOs and hospital services to meet the needs of the priority groups, including a social marketing campaign and social media campaign.

21 The Smokefree team will raise awareness within the community of the Government's smokefree 2025 goal with a focus on increasing support for, and actions towards, this goal within the community.

22 The Smokefree team will continue to work with member agencies of the Northland Intersectoral Forum in the development of their smokefree policies and associated actions in support of the Smokefree 2025 goal.

23 The Smokefree team will promote group-based treatment in the community in areas and environments where Maori are high service users.

24 NDHB will highlight the 'cost of smoking' in all wards to staff, patients and whanau.

25 Work will continue with territorial local authorities to extend their current smokefree policies and increase smokefree environments.

26 Ongoing support for workplaces, schools and community organisations in developing or extending smokefree policies.

27 Make submissions to TLAs and central government on tobacco control issues.

28 Provide regular media releases on tobacco control issues.

29 Provide quarterly educational and legislative updates to tobacco retailers.

30 Scope and develop a Maori-focused strategy to reduce the uptake of smoking, and promote auahi kore amongst youth (up to 25 years).

31 Develop an iwi-lead initiative towards Tupeka Kore-Smokefree Tai Tokerau 2025 in collaboration with iwi runanga.

32 Work closely with Aukati Kai Paipa providers on the delivery and reach of Whanau End-smoking Regional whanau Ora challenge (WERO).

33 Coordinate the Tai Tokerau Hapunga Auahi Kore Alliances to improve support to Maori pregnant women to quit smoking.

34 Coordinate and monitor the 'Smokerlyzer for Midwives' project to support Maori pregnant women to increase referrals of mothers who smoke to cessation support services.

35 Maintain coordination of the regional Patu Puauahi Tobacco Control network to target Maori-led initiatives.

36 Facilitate the provision of Heart Foundation smoking cessation trainings.

Compliance:

37 Conduct Controlled Purchase Operations and compliance visits at tobacco retail outlets.

Measuring and monitoring performance

We will measure and monitor our performance of targets, with a focus on eliminating inequity:

95% of hospitalised patients who smoke are offered brief advice and support to quit smoking by June 2016.

90% of PHO-enrolled patients who smoke have been offered brief advice and support to quit smoking by a health care professional in the last 15 months.

90% of pregnant women who smoke at the time of confirmation of pregnancy are offered brief advice and support to quit smoking by a health care practitioner.

90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.

Increase enrolments to 5% of smokers per annum.

Achieve 50% of carbon monoxide-validated quits at 4 weeks and 3-6 months when working with clients and whanau who smoke and have set a target quit date.

Quarterly reporting to monitor performance against targets and indicators, with a requirement to develop action plans if not reaching target.

2.2.6 Childhood obesity

↪ NRHP 4 Our Intervention Logic and Regional Targets, National Health Targets

What outcomes are we trying to achieve?

Northland DHB will address the inequities between Maori and non-Maori children, reducing the overall rate of childhood obesity in Northland.

By December 2017, 95% of obese children identified in the Before Schools Checks (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

Children will receive a comprehensive check before entering school via our B4SC programme. The new referral routes established through the expanded service will be fully embedded. The programme will be achieving positive outcomes for children and whanau who have been referred for additional support and will:

- increase overall health literacy
- synergised messages across the maternal and child health continuum to promote tamariki ora
- support and improve access for Maori to quality services that reinforce whanau ora
- enable whānau to make healthy food choices
- increase whanau and tamariki participation in meaningful activity
- lead to a reduction of childhood obesity in Tai Tokerau.

Why is this important for community and patients?

Northland's tamariki Maori are disproportionately affected by childhood obesity compared with non-Maori children. In Tai Tokerau, 16% of Maori children are obese and a further 1 in 3 are overweight. This compares to 8% of non-Maori children being obese and 1 in 5 being overweight. This means that almost half (46%) of Maori children are either overweight or obese, 16% higher than non-Maori children.

Children who are overweight and obese are likely to stay obese into adulthood and are therefore more likely to develop non-communicable diseases such as diabetes and cardiovascular diseases at a younger age. Development of these long term conditions leads to poorer health outcomes, and contributes to lower life expectancy. Overweight and obesity, as well as their related diseases, are largely preventable. Prevention of childhood obesity is therefore a high needs priority.

By synergising the health messages across the maternal and child health continuum, whanau will have multiple support mechanisms to access support and promote:

- breastfeeding
- well nourished children as they grow
- physical activity for children.

Actions planned for 2016/17

1 To improve coverage ensure:
   - the monitoring reports from the lead provider of the B4SC programme demonstrate that high quality checks are conducted, reviewed quarterly against Ministry targets are reviewed each quarter
   - the health target for 95% of children identified are referred for clinical assessment is achieved by December 2017; to be reviewed each quarter. Meet with the lead provider bi-annually to assess performance, establish strengths and opportunities for further improvement.

2 Ensure that the service provider is delivering culturally appropriate interventions to tamariki Maori and whanau, maximising engagement and outcomes through development of appropriate feedback mechanisms and case studies highlighting individual successes.

3 Working with stakeholders across Northland to develop robust, clear and effective referral pathways – the lead provider will focus on supporting iwi providers, to enable children living in high deprivation areas to access programmes by working with the lead provider to establish rollout of the new programme, prioritising areas of high deprivation and access to Maori tamariki. New referral pathways to be clearly communicated and established by Q1 2016/17.

4 Continue to engage with Te Roopu Kai Hapai Oranga (Northland Alliance Leadership Team) to ensure that resources are dedicated to the identification and provision of services to Maori tamariki that have been identified as overweight or obese through the Before Schools Checks.

5 Strengthen Caring for our Future – Child Health Service Level Alliance Team (SLAT) to have strategic oversight of the performance of childhood obesity services, liaising closely with the stakeholders within the community with a focus on reducing health inequities for tamariki in high needs areas.

6 Consult with providers, referrers, general practice, whanau and stakeholders to establish efficacy of service by December 2016. The outcome of the review to inform service delivery and contracting arrangements with appropriate changes agreed, service specifications changed and providers in place for start of contracts on July 2017.

Future development:

7 Subject to funding confirmation, new services designed with stakeholder engagement, quarterly milestones and planned activities will be agreed to roll out. Fully embed, promote and utilise the newly established intervention programmes that offer high quality outcomes to tamariki and whanau who have been referred for additional support. The service will demonstrate high levels of collaboration between the DHB, PHOs and community partners to ensure whanau experience a seamless transition between services.

Measuring and monitoring performance

Performance will be measured against the target 'by December 2017, 95% of obese children identified in the Before Schools Checks programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions'. This will be conducted through the data gathered by providers that is submitted monthly.

As and when Ministry funding is confirmed, new services will be implemented with stakeholder engagement to design appropriate interventions for children identified in the Before School Checks to reduce their weight, and improve health literacy of the whanau. Quarterly milestones will be agreed on confirmation of the level of funding.

Referral and outcomes data will be monitored to ensure that the targeting of funding to tamariki Maori is effective. This will be indicated through a reduction of inequities in the data. Quarterly monitoring will be derived from the Before School Check data.

Case studies of success stories that capture the holistic benefits of the programme will also be collated, reviewed and shared with others.

The Before School Check service will hit the target of 85% of tamariki Maori to offer a check to high needs children by quarter 2.

2.3 System integration

↪ NRHP 2 Northern Region Context \ Drivers for change \ Care closer to home
3 Our direction \ N. Region Future Landscape \ Better integration across services

Fit for Life is one of three priorities for the Alliance Leadership Team (the others are 2.3.8 Rural SLAT and cardiac rehabilitation which comes under 2.8.3 Cardiac services).

2.3.1 NHSP Fit for Life – obesity

The Fit for Life Obesity project is one of the projects under the Northland Health Services Plan.

What outcomes are we trying to achieve?

A Tai Tokerau Childhood Obesity Prevention Framework was endorsed by Northland's Alliance Leadership Team in December 2015. The goal of the framework is 'To increase the number of Maori tamariki who are at a healthy weight by 5% through good kai in five years (2021)'.

The strategic objective of the framework is to:

Create environments that support healthy eating for all tamariki in order to:

- reduce consumption of energy-dense foods
- increase consumption of fruits and vegetables
- decrease consumption of sugary sweetened beverages
- raise awareness of good nutrition.

The priority groups that all initiatives will target are mama and pepi, and tamariki up to the age of 10 years, with a focus on Maori and the obesogenic environment.

This framework provides a robust platform for all Tai Tokerau agencies and other oganisations to build an effective, integrated response to one of the biggest health challenges that we are facing. It will allow initiatives to be developed that will start a shift toward healthy food being more desirable, accessible and affordable. It will allow a coordinated approach for work to occur across multiple levels in the food system to help create an environment that supports healthier eating, enabling us to increase the number of tamariki who are at a healthy weight in Tai Tokerau.

In May 2016 Northland's Alliance Leadership Team endorsed the Work and Investment Plan, consisting of 12 initiatives to be delivered across the four workstreams of Food Security, Sugar Sweetened Beverages, Advocacy and Policy and Health Literacy. These initiatives include a mix of the establishment of new services, extension of existing services, investing in time-bound projects and influencing the focus of existing services.

Why is this important for community and patients?

The burden of obesity is not equally shared in New Zealand, with higher rates in the Maori and Pacific Island populations. In Northland 50% of Maori adults are obese, compared to 28% of non-Maori.

There is a clear association between deprivation and obesity. The obesity rate is much higher among people living in the most deprived neighbourhoods (44%) than in people living in the least deprived neighbourhoods. Children living in the most deprived areas were three times more likely to be obese than children who live in the least deprived areas. Of particular concern is the increase in the rate of childhood obesity from 2006/07 (8%) to 2012/13 (11%). This increase is occurring in the context of plateauing or even decreasing rates of childhood obesity in many other OECD countries.

Maori tamariki in Tai Tokerau are disproportionally affected by obesity and overweight. About one in six (almost 16%, or 2,561) Maori children are obese, double that of Northland non-Maori children (1,183 or 8%). A further one in three (more than 30%, or 5,000) of Maori tamariki are overweight, compared to 3,294 (22%) of Northland non-Maori children. This means that almost half (46%), or 7,532 of Maori children are either overweight or obese, 16% more than non-Maori children in Tai Tokerau.

Actions planned for 2016/17

1 Further development of initiatives.

2 Development of funding applications.

3 Recruit FTE where required.

4 RFP process where required.

5 Development of communication resources and implementation of the strategic communications plan.

6 Further development of partnerships specific to interventions.

7 Begin phased implementation of interventions.

Measuring and monitoring performance

Baseline measures will be established for the obesity prevention frame work goal and the four strategic objectives. All initiatives and interventions developed within each workstream will include clear outcome measures to enable the effectiveness of each to be measured.

2.3.2 NHSP Neighbourhood Healthcare Homes (NHH)

↪ NRHP 2 The Northern Region Context \ Drivers for change \ Care closer to home

The Fit for Life Obesity project is one of the projects under the Northland Health Services Plan.

What outcomes are we trying to achieve?

The Neighbourhood Healthcare Home is a team-based and locality-networked primary healthcare delivery model led by primary care clinicians that provides comprehensive and continuous health and social care, with the goal of supporting individuals toward better health outcomes. It is a fully integrated, multidisciplinary team of providers. It is accountable for the health and wellness of its enrolled

population and ensuring equitable access to its services for enrolled patients. It is the hub that delivers and coordinates high quality, equitable healthcare.

The purpose of the NHH is to enable General Practice – and the health system as a whole – to become more effective, sustainable and, ultimately, beneficial. To this end, the NHH will shift the broader health system to focus on a more patient-centric approach, rather than the existing service based one. It will streamline operations and change the way patients and clinicians interact, improving the patient's journey through the health system by moving from reactive to proactive health care.

A key outcome of the initiative will be the creation of greater capacity in primary care, so that additional services can be delivered to those that need it the most. This will result in more care taking place closer to home and a reduction of pressure on secondary services.

The NHH supports new look General Practice teams that include GPs, Practice Nurses, Nurse Practitioners, Practice Team Assistants, Physician Assistants, Navigators, Community Pharmacy and Community Nursing. The additional enhanced services are designed specifically to improve quality of services to patients with chronic conditions and high needs as well as meet acute demand.

NHH will also see greater accountability to patients and communities around their community based services by being more transparent and open around care and options.

To achieve this, the healthcare home changes the way services are commissioned from a traditional partial capitation and fee for service co-payment based model and focuses on the provision of patient centric services in community settings through a more flexible use of both government and patient funding.

Why is this important for community and patients?

The purpose of the Health Care Home is to enable General Practice - and the health system as a whole - to become more effective, sustainable and, ultimately, beneficial. To this end, the Health Care Home will shift the broader health system to focus on a more patient-centric approach, rather than the existing service based one. It will streamline operations and change the way patients and clinicians interact, improving the patient's journey through the health system by moving from reactive to proactive health care.

Actions planned for 2016/17

1 In collaboration with the two PHOs there will be support for up to 8 practices/networks to develop into NHHs which will involve practices developing systems and processes to improve and/or implement:
   - equity management
   - call management
   - doctor triage of patients
   - clinical and administrative pre-work
   - engagement with new model of nursing care
   - planned year of care
   - extended hours
   - patient and whānau centric appointments
   - expanded use of roles and new roles
   - applying lean principles to facility layout and practice processes
   - telephone consultations with doctors and nurses
   - patient portals
   - consumer and community engagement
   - integration with social and community sector
   - quality and safety.

2 NDHB support will be:
   - leadership
   - project management
   - change management
   - business analysis
   - additional investment in primary care.

Measuring and monitoring performance

Q1	Q2	Q3	Q4
Joint NDHB/ PHO Change management team established Joint NDHB/ PHO Change management team training completed Up to eight NHH practices have completed the business analysis and agreed to continue Dashboard indicators agreed PHO agreements signed Four practice change plans agreed	A further 4 NHH practices (maximum) have completed the business analysis and agreed to continue PHO agreements signed Remaining Practice change plans agreed Implementation in progress	Implementation in progress	Implementation in progress Report on indicators

2.3.3 Primary Options

What outcomes are we trying to achieve?

The goals of the Northland Primary Options Programme are to reduce referrals and hospital admissions through the provision of an appropriate range of services in the primary care setting, and to facilitate early and effective discharge from hospital into primary care through avoiding escalation of care to reduce ED presentations.

Northland Primary Options aims to improve integrated work and develop a whole-system perspective to enable quality improvement, raise the profile and recognise the capability and contribution of primary care. We will build on community infrastructure, effective and efficient use of resources, increase the options available for acute care in the primary setting and have professionals working to the top of their scope.

Why is this important for community and patients?

Services are closer to home and community and place the patient at the centre of care, which allows us to address equity and access issues for the community.

It informs future models of care and enables effective use of resources.

Interface working is improved.

It enables the development integrated care pathways and strengthens primary care health and resources.

It reduces avoidable hospital admissions and length of stay.

Actions planned for 2016/17

1 Develop new clinical pathways for:
- Iron Infusion in the community by Q2
- Zometa Pathway in addition to the Zoledronate pathway by Q3
- child health (including eczema, the viability of which will be explored) by Q4
- addition to the current early discharge pathway to include home based supports by Q4.

2 Workforce development of primary care nurses and general practitioners:
- IV cannulation and therapy designations
- provide ongoing education/information on all new pathways across Northland.

- diagnostics
- working collaboratively with hospital specialist teams.

3 Service delivery:
- work collaboratively with NDHB to improve referral process and reduction of ED admissions
- work collaboratively with GPs and General Practice teams to improve referral and claims process
- work collaboratively with Tai Tokerau PHO in the provision of Primary Options services across Northland

4 Equity:
- ensure that each General Practice dedicates Primary Options resources effectively to their high needs populations
- monitor clinical pathways for factors that facilitate or act as barriers in achieving health equity for Maori
- monitor how many Māori are being referred compared with how many present to hospital by condition, utilising referral data and ED / hospital admission rates data

Measuring and monitoring performance

1,000 referrals within twelve months.

New pathways developed for Iron Infusions, Zometa, child health, home based supports.

100 Iron Infusions by June 2017.

Access of care for high need populations measured (% of Māori referrals received; % of pathways developed that meet Maori Healthcare framework).

Measure reduction of hospital admissions and presentation to ED, and increase in early discharge pathway use.

Measure length of stay in service and outcome of care.

2.3.4 Telehealth

↪ NRHP 5 Enablers \ Information systems

What outcomes are we trying to achieve?

Deliver health services using communications technology across the Northland health sector in support of the objectives of the Northland Health Services Plan.

Why is this important for community and patients?

The key driver is to deliver health services closer to home for patients with benefits such as less travel, cost and fewer hospital touch points such outpatient clinic visits required (consistent with the aims of 2.3.2 NHSP Neighbourhood Healthcare Homes). These benefits correlate to staffing and organisational time as well as cost savings.

Telehealth has the potential to improve patient safety because it provides upskilling and workforce enablement as a natural byproduct of its use, particularly for remote and rural care.

Actions planned for 2016/17

1 Continue to grow the outpatient telehealth clinic service.

2 Expand use of telehealth in acute care and evaluate effectiveness. District Hospital EDs using telehealth by Q4.

3 Trial and evaluate telehealth in clinical settings in primary care with view to upscaling if clear benefits are shown. One model of care trialled by Q4.

4 Reduce impact of distance by linking up rural and remote locations to central secondary and tertiary care locations.

5 Develop requirements that articulate the needs of the region in the use of telehealth. Completed by Q3.

6 Develop a regional health sector technology solution in partnership with the region's health providers. Videoconferencing solution confirmed by end of Q4.

Measuring and monitoring performance

>600 individual patient outpatient clinic appointments for year ending 31 December 2016.

Grow acute care network to include Bay of Islands Hospital and Dargaville Hospitals.

Progress telehealth steering group-sanctioned initiatives with primary care organisations and evaluate their effectiveness.

Publish DHB-wide standards and guidelines for telehealth outpatient clinics.

Research paper and multiple case studies from acute care project published by the end of 2016.

2.3.5 The Mental Health Stepped Care Model

NRHP 2 The Northern Region Context \ Drivers for change \ Care closer to home
4 Our intervention logic and regional targets \ Key service delivery areas \ Mental health and addictions

What outcomes are we trying to achieve?

Implement a Stepped Care Model as the framework for service delivery in mental health which aims to improve the experience of patients with mental health issues by:

- recognising and responding to mental health and addiction needs
- taking account of physical needs of patients with mental health and addiction issues
- increasing timely access to organised mental health and addiction responses at the most appropriate level across primary and secondary care
- supporting primary and specialist services to work together to provide shared care arrangements and improve the provision of step-down support.

Why is this important for community and patients?

Care provided using the Stepped Care framework will help ensure the most effective mental health and/or AOD care for the greatest number of people is delivered at the right level and by the most appropriately trained health professional. It is important that attention to the physical health of patients with mental health and addictions issues is given.

Actions planned for 2016/17

1 The workforce across the care continuum will receive training in the Stepped Care Model to develop confidence and competence in the area of care relevant to their specific scope of practice. Shared training will be key to improving understanding of the respective roles of the primary and secondary services.

2 Primary health care nurses will be supported to participate in a primary mental health credentialling programme.

3 Clearly documented access criteria and protocols will be developed, and mechanisms implemented to ensure these are adequately communicated.

4 The requirement for the service to be provided by 'suitably qualified health practitioners' will be audited and documented (this term is defined as a health practitioner who is sufficiently qualified, registered through an appropriate regulatory body and experienced to diagnose and manage mental health and/or AOD illnesses across the care continuum).

Measuring and monitoring performance

Increase in the number of patients completing self-management workshops.

Reduced incidence of admissions for acute mental health episodes.

Reduction in complaints and significant events received.

Consumers and families/ whanau are at the centre of care, with a focus on the best possible outcomes for vulnerable populations.

Patients experience timely access to interventions and services.

Services are effective and well integrated in a highly collaborative environment.

Best use of public funds and value for money.

Evidenced-based practice and consistent models of care are explored and implemented.

Services provided within budget.

Patients and whanau indicate improved satisfaction in relation to care received.

2.3.6 Care Connect

NRHP 5 Enablers \ Information systems

What outcomes are we trying to achieve?

The Care Connect Programme is a regional initiative by the four Northern Region DHBs (Auckland, Counties Manukau, Waitemata, Northland) to improve information sharing among community and hospital healthcare providers for the benefit of patients.

More specifically this will facilitate the beginning of an electronic health care record, enable clinical partnerships that span across the health continuum and ensure the right information is available at the right time by the right provider.

Why is this important for community and patients?

Information sharing helps healthcare providers 'complete the picture' so they provide the best care to their patients as quickly as possible. It increases the range of information available to all care team members involved. It will also facilitate active participation of patients as partners in care by allowing them visibility and interaction with their key health information.

Actions planned for 2016/17

The Care Connect Programme will continue to work at a regional level to best leverage shared knowledge, resources and clinical expertise. All the Northern DHBs have a desire to improve the patient journey and are aligned in their vision for multi-disciplinary, patient centric integrated care using IT solutions as key enablers.

More focus will need to be spent on how we implement IT projects to the clinical staff and patients who are using them. The IT is only an enabler for change so to get the best outcomes for patients and providers we need to be better at supporting the change management involved in our projects.

1 Continue localising static pathways and enhancing usability of dynamic pathways.

2 Increase the number of practices and patients who are using the Patient Portal.

3 Ensure single sign on becomes available to GPs.

4 Complete scoping and requirements for the Primary Care Data Repository.

5 On completion of the e-Shared Care IPS start work on implementation of e-Shared care in alignment with Northland's Neighbourhood Healthcare Homes work stream.

Measuring and monitoring performance

NDHB will be contributing a minimum $342k towards the capital costs of these programmes and $98k towards operational costs.

Track the utilisation of both static and dynamic pathway use and assess the clinician satisfaction with the pathways. Remain involved in the regional clinical pathways steering group.

Install, implement and support e-Shared Care records. Track number of patients put on a e-Shared Care record and audit quality of records/provider and patient satisfaction. Continue to work with vendor to enhance the product with a view to having the record used by NGOs, GPs, secondary providers, patients and social service agencies.

Track the number of general practices offering a patient portal and the number of patients using the portal. Encourage practices to take up a patient portal and encourage patients to sign up for a portal.

2.3.7 Community pharmacy

NRHP 2 The Northern Region Context \ Drivers for change \ Care closer to home

What outcomes are we trying to achieve?

In line with the national Pharmacy Action Plan, develop and promote pharmacists working to the top of their scope, offering additional services to patients that add value to health outcomes.

Reduce inequities experienced by Northlanders living in rural and deprived communities by identifying opportunities for pharmacies to deliver more health services in the community, closer to patients and whanau and removing cost barriers where possible.

Continue to provide, and where possible (subject to funding) expand the Stop Gout project, SSRI project, and OAC project.

Explore, identify and invest in pilot projects which can contribute to the elimination of health inequities for Maori in communities by offering opportunistic health literacy education and intervention services.

Reduce unnecessary polypharmacy, increase health literacy and build multidisciplinary community health services through the implementation of a Community Pharmacist Facilitator service.

Why is this important for community and patients?

Delivering patient-centred services closer to home for individuals and whanau is a priority. By delivering additional patient services in community pharmacy we can reduce the cost burden on patients and increase the efficiency of appointment systems in general practice.

By increasing collaboration between pharmacy and the wider health sector, patients will have access to a continuum of preventive and curative services, according to their needs, over time and across different providers of the health system closer to home. This will give patients greater choice over where they receive their treatment.

Many Northlanders, especially Maori, cannot afford to access primary health care (in the 2011-14 NZ Health Survey, 20% of Maori and 8% of non-Maori said they had an unmet need for a GP due to cost). By investing in programmes that can be delivered in community pharmacy, we can have some impact in reducing health inequalities that result.

Identifying unnecessary polypharmacy and opportunities for improved prescribing will increase health outcomes for Northlanders in our community. It will:

- reduce the overall cost pressures on pharmaceutical budgets and patients copayments
- improve health literacy through medicines usage reviews
- improve outcomes for patients and whanau through reducing unnecessary polypharmcy
- improve clinical prescribing behaviours through sharing of best practice
- build multidisciplinary approach to primary care and improving patient and whanau experience of primary care.

Actions planned for 2016/17

1 Continue to work closely with the Northland Community Pharmacy Services Development Group and build upon the Pharmacy Action Plan to identify further opportunities for pharmacies to offer treatment, health literacy and services to patients closer to home that will contribute to the goal of eliminating health inequalities for Maori. NDHB will continue to participate in the national process to commission services in the community that cost-effectively match supply to need.

2 Community Pharmacy will be represented at Northland's Rural Service Level Alliance Team (SLAT), further developing strategic opportunities to develop a multidisciplinary approach to shifting service to the community under a primary care setting enabling pharmacists to operate at the top of their scope.

3 Implement a Community Pharmacy Facilitator service initially in North Whangarei, evaluating outcomes to build a business case to expand the service in future years.

4 Explore the possibility of offering funded tobacco cessation services, with a focus on Maori, delivered in community pharmacy as part of a wider refresh of tobacco control measures at NDHB.

5 Explore the possibility of offering Emergency Contraceptive Pill (ECP) as part of a wider Sexual Health Plan and opportunistic sexual health advice delivered in community pharmacy (subject to funding approval and meeting governance standards).

6 Continue to offer stop gout programme, SSRI counselling and OAC services in pharmacies across Northland.

7 Continue to support the national Pharmacy Action Plan.

8 Support the work being undertaken by all DHBs to develop a National Framework for Pharmacist Services in the community, ensuring that Northland's populations needs are met.

9 Support the development and implementation of a sustainable solution to the pharmaceutical margin and other supply chain issues.

Measuring and monitoring performance

Continued and where possible increased investment in existing community pharmacy services.

If the RFP is successful, smoking cessation services will be implemented in community pharmacies.

ECP services implemented in pharmacies.

Implemented Community Pharmacy Facilitator role with agreed outcomes of reduced cost burden from unnecessary polypharmacy, improved multidisciplinary cultures in primary care, better health outcomes for patients and whanau that have received a medicines use review.

Continued outcomes being achieved from stop gout programme, SSRI counselling and OAC services in Northland community pharmacies.

2.3.8 Rural Service Level Alliance Team (SLAT)

NRHP 2 The Northern Region Context \ Drivers for change \ Care closer to home

Rural SLAT is one of three priorities for the Alliance Leadership Team (the others are 2.3.1 NHSP Fit for Life – obesity and cardiac rehabilitation, which comes under 2.8.3 Cardiac services).

What outcomes are we trying to achieve?

Accessible primary care for Northlanders in rural areas out of hours.

A multi-skilled and sustainable workforce in rural Northland that is able to meet the needs of patients.

Models of care which provide services to patients closer to home.

Why is this important for community and patients?

Around 92,000 of Northland's patients are enrolled in non-Whangarei general practices. Access to out-of-hours services in rural Northland is therefore a priority to ensure high quality health services.

Many of Northland's rural communities fall into decile 4 and 5 and are high needs. It is important to consider the impact of accessibility for out-of-hours care for this population in terms of cost and distance.

Northland's primary care workforce is aging. Attracting and recruiting a skilled, multidisciplinary general practice workforce to ensure sustainability is essential to ensure rural Northland's primary health care needs are met.

Developing new models of care that provide care closer to home for patients in Northland will require a skilled, multidisciplined workforce. Preparing our workforce for future needs requires investing in our workforce today.

Actions planned for 2016/17

1 Continue our investment commitment to Northland's Rural SLAT (Service Level Alliance Team) to enable them to make recommendations to ensure that the outcomes we have set out are achieved.

Initial planning be complete by Dec 2016, with commissioning and contracting negotiations completed by May 2017 with a view to new contracts being in place to commence 1/7/17.

2 Under direction of the Rural SLAT evaluate current out-of-hours service provision by Dec 2016 and design sustainable and accessible models of care that reduce inequities and purchase services from general practice that meet these needs by June 2017.

3 Realign the Rural Workforce Development and Retention service with a strategic aim to address short, medium and long term rural workforce needs. The service to specifically provide capacity to primary care to:
- increase top of scope practice for nursing
- provide innovative retention programmes
- focus resourcing on high-risk smaller practices
- conduct risk assessments on primary care practices regarding sustainability of service provision.

The service to transition to the new specification with a period of implementation. Initial reporting on progress by quarter 1 with establishment completed by quarter 2.

Measuring and monitoring performance

After-hours contracts will be in place that reduce inequities and barriers to access out-of-hours care in rural Northland.

A reinvigorated 'Rural Workforce Development' contract will be in place with a view to meeting current primary care needs that:
- builds capacity for staff to work at the top of their scope
- is focussed on recruiting and attracting a high calibre multidisciplinary primary care workforce.

2.4 Health of older people

↪ NRHP 4 Key service delivery areas \ Health of older people

2.4.1 System integration for older people

What outcomes are we trying to achieve?

Provide care and support to the complex and fragile HOP population in the community.

Improve communication of health information between client, their families and primary and secondary care.

Why is this important for community and patients?

The ageing population is increasing demand on secondary care. Northland DHB's HOP gerontology nurses and ARRC practice development coordinator(s) aim to identify issues in the community (early intervention), minimise their impact to reduce acute demand (hospital avoidance), and improve the patient, family and whanau experience of hospital and community and primary care services.

Delays in the flow and coordination of laboratory information can also result in delays in timely care and treatment with poorer ARRC resident outcomes.

Actions planned for 2016/17

1 Continue to increase the number of contacts and exchanges of information between the HOP Gerontology Nurses and GPs and primary health care teams.

2 Gerontology Nurse Specialists (GNSs) to complete ACP training.

3 Establish a programme for GNSs to provide ACP with community clients.

4 Work in partnership with GPs in ARRC to implement timely responses to integrated laboratory information and results.

5 Provide supporting information and education to ARRC facilities so they can pilot accessing "Testsafe" by Q4.

6 Continue with GNS support and education days between HOP and primary care teams.

Measuring and monitoring performance

Number of GP and primary health care team contacts.

Number and percentage of cases referred to primary and community services (hospice, Iwi/Maori providers, Alzheimers Society etc), including ethnicity.

Number of GNSs who have completed ACP training and the level they have achieved.

Number of ACP conversations for GNS community clients.

Number of primary care education days and attendance rate.

ARRC practice development, pilot targets:

Measure	Quarter			
	Q1	Q2	Q3	Q4
ARRC facilities utilising "Testsafe"	25%	50%	75%	100%
ARRC GP contacts completed	25%	50%	75%	100%

2.4.2 Comprehensive clinical assessment in residential care and in home and community support settings (interRai)

↪ NRHP Top 19 priorities, no. 3

What outcomes are we trying to achieve?

Older people receive best practice care that is based on a comprehensive assessment to find opportunities for improvement and/or risks to the older person's health, which then form the basis of a care plan.

Why is this important for community and patients?

The use of InterRAI is mandatory in all New Zealand aged residential care facilities. It is also used by DHBs to assess the care and support needed by older people living in their homes.

InterRAI provides comprehensive assessment of a person's medical, rehabilitation and support needs, and abilities such as mobility and self-care. The information gathered helps nurses to write tailor-made care plans to benefit the client.

Providers are able to compare information about their residents and standardise care. We can gather anonymised information about the needs of our older people, which helps the sector to improve and develop services.

Actions planned for 2016/17

1 Participate in the development of nationally integrated InterRAI education and support services.

2 Northland DHB NASC to continue to carry out InterRAI Home Care and Contact assessments in order to meet Ministry requirements as follows:
- All older people receiving long term home and community support services have had an interRAI Home Care or Contact assessment and a completed care plan
- Older people admitted to an aged care facility have been assessed using an InterRAI Home Care assessment tool in the six months prior to the first Long Term Care Facility (LTCF) assessment.
- Older people referred for an interRAI assessment to access publicly funded care services will undergo the assessment and have a service allocated or declined in a timely manner within the NASC performance and monitored timeframes.

3 Use InterRAI measures from the National InterRAI centre to progress and monitor performance, particularly equity of access by ethnicity to an InterRAI assessment.

4 Continue to develop an automated solution for reporting time taken from any referral source to completion of an interRAI assessment, comparing performance with Northern Region DHBs.

5 Continue to identify opportunities for the application of InterRAI assessment across the continuum of care, and other primary and community settings.

Measuring and monitoring performance

To measure InterRAI performance, data is collected and analysed for the four northern DHBs by Northern Regional Alliance. The national interRAI data centre is also a source of data for DHBs.

Number of older people who received long term support services for home and community supports and % who have had an InterRAI Home Care or a Contact assessment and completed care plan.

As at the end of quarter 3 2015/16, 77% of the total number of long term Home and community Support Services clients had had an interRAI assessment. Based on an increase of about 4% per quarter, we are on track to achieve 95% by the end of 2016/17.

% of people in aged residential care by facility and by DHB who have a subsequent interRAI LTCF assessment completed within 230 days of the previous assessment.

We will monitor the performance of ARRC providers completing LTCFs, based on the data provided to us by the National InterRAI data centre. Northland currently sits slightly above the national average and we hope to further improve on this result.

% of LTCF clients admitted to an aged residential care facility who have been assessed using an interRAI Home Care assessment tool in the six months prior to that first LTCF assessment.

We will monitor the performance of ARRC providers completing LTCFs, based on the data provided to us by the InterRAI National Data Analysis Reporting Centre data centre. Currently we have no baseline data for this, but the national centre hopes to have this available by October 2016 in time for quarter one reporting.

Show time taken from any referral from any source to complete (not triage) an interRAI assessment (that is, Contact, Minimum Data Set-Home Care, LTCF assessment).

Northland DHB's NASC has established the following targets from receipt of referral to completed Contact or Home Care InterRAI assessment:

- urgent priority referrals: assessment completed within two working days
- non-urgent priority referrals: completed assessment within 15 working days.
- complete service coordination within 15 working days.

Reporting mechanisms are in place.

2.4.3 In Between Travel

What outcomes are we trying to achieve?

Implementation of Northland DHB's statutory obligations arising from the In Between Travel (IBT) Settlement Agreement reached by all DHBs, Ministry of Health, providers and unions.

The Settlement's agreed outcomes are:

- putting in place a funding and reimbursement process for travel time and travel cost that employees incur in delivery of home and community support services
- development of sustainable home and community support services, including a regularised workforce.

Why is this important for community and patients?

Over two thousand older people in Northland receive long term care delivered in their homes by home and community support services.

The full settlement would support the development of a trained, regularised workforce and can more adequately provide for the increasing complexity of those who choose to remain in their own homes.

Actions planned for 2016/17

1 Northland DHB is represented in this action by the national Health of Older People Steering Group.

2 Northland DHB will continue to carry out the requested actions as nationally agreed, to achieve the Settlement Agreement outcomes.

Measuring and monitoring performance

Supporting the In Between Settlement agreement outcomes within agreed timeframes.

2.4.4 Dementia Care Pathway

What outcomes are we trying to achieve?

Earlier diagnosis and support for those experiencing cognitive impairment, and equitable access to health, community and social services.

Why is this important for community and patients?

The prevalence of dementia is around 35% for those over 85 years (support, advice and care is provided to around 500 new dementia patients a year across Northland). In Northland this age group will double in number over the next ten years, increasing demand for specialist services, residential services and inpatient Mental Health Services.

In the 2015 calendar year Northland's Alzheimers Society provided information, advice, education and support for an active caseload of 426 people with dementia and 385 direct carers. 41 clients with dementia live alone.

The number of Maori and Pacific people living into their middle-age years will increase and their prevalence of dementia will grow. By 2026 it is predicted that of those diagnosed with dementia 5.7% will be Maori and 2.6% Pacific. Without regular and ongoing cognitive assessment of people with frailty and complex health conditions, the burden of which is largely carried by Maori and Pacific whanau/ fono, early onset dementia may be missed or ignored.

Northland's prevalence calculations are conservative as differences related to ethnicity and risk factors such as alcohol and drug dependency, prison population and vascular and diabetes risk factors are not allowed for.

Northland DHB seeks to introduce a primary care-led dementia care coordination pathway to improve earlier access to primary and community advisory, information, education and support services for dementia patients, their families and carers.

Actions planned for 2016/17

1 Continue to develop and implement the Northern Regional Clinical Pathway for the management of cognitive impairment and the localised Northland static pathway, increasing the number of general practices and primary health care teams using the pathways, with direct electronic referrals to Northland Alzheimers Society.

2 Provide detailed information of dementia education and support programmes in operation to support informal carers and people living with dementia (as per the NRHP) engaging with consumers and whanau to assess equity of access by ethnicity, locality, source, acceptability, variability and sustainability.

3 Complete the evaluation of the Mid North primary care-led Dementia Care Coordination Pilot programme in primary care, including a kaupapa Maori service (Q1).

4 Consider full roll-out of the Dementia Care Coordination Pathway based on the Mid North pilot evaluation (Q2).

5 Further engagement with Maori whanau to support ongoing review, design and implementation of support for Maori.

Measuring and monitoring performance

Clinical pathways:

- number and proportion of general practices and primary health care teams using the clinical pathways for managing cognitive impairment.

- number of people on the clinical dementia pathway including ethnicity, age and gender. Reports will be sent quarterly to MoH.
- number of new clients referred to Alzheimers Society by primary health care services (baseline for 2015 calendar year: 26% of total referrals) and increase in number of referring GPs. Reports will be sent quarterly to MoH.
- number of patients referred to secondary care not on pathway including ethnicity, age and gender.

Detailed information of dementia education and support programmes:
- documented detailed report (timeframe to be set, align with NRHP).

Evaluation of Mid North Care Coordination pilot:
- written evaluation report and recommendations, with RBA indicators and measurement for future service delivery and contracting.

Further engagement with Maori whanau:
- number and frequency of consumer and Maori whanau engagement in support service design. Progress reports will be sent quarterly to MoH.

2.4.5 Falls and fractures

What outcomes are we trying to achieve?

The aim of the Fracture Liaison Service (FLS) is to ensure that all women ≥50 years and all men ≥60 years presenting to urgent care services with fragility fractures receive assessment and treatment, where appropriate for osteoporosis, and referral to local falls prevention services to reduce their risk of subsequent fractures.

Why is this important for community and patients?

Hip fractures are costly to patients and the New Zealand health care system.

In the 2015 calendar year there were approximately 348 fragility fractures in Whangarei Hospital's acute services, about 30% (107) of which were hip fractures. These hip fractures cost Northland DHB approximately $2,856,000.

Half of hip fracture patients suffer a fragility fracture of the wrist, shoulder, humerus, hip or other skeletal sites prior to breaking their hip. Identifying people when they first present with a fragility fracture will reduce the number of those who go on to have a hip fracture later in life.

After observing the outcomes seen elsewhere it is predicted we will reduce secondary hip fractures by 20% by implementing our Fracture Liaison Service.

Only half of those who survive a hip fracture will walk unaided again and many will not regain their former degree of mobility. Between 10% and 20% will be admitted to residential care as a result of the fracture. 60% will require assistance with activities of daily living a year after the event. 27% will die within a year of their hip fracture, and of these, just under two-thirds would not have died if they had not fractured their hip.

Osteoporosis treatments subsidised by the Ministry of Health have the potential to halve secondary hip fracture incidence if initiated when patients present to hospital with their first fragility fracture.

Actions planned for 2016/17

1 Continue to collect data and report on fragility fractures.

2 Continue to case-find all patients presenting with fragility fractures to Whangarei Hospital, supporting access to the right clinical pathway, including appropriate osteoporosis treatment.

3 Continue to establish systems for FLS networking within the hospital to ensure no fragility fractures are missed.

4 Participate in Fracture Liaison Service planning days in conjunction with other DHBs' Fracture Liaison Nurses, ACC, HQSC, MoH and Osteoporosis NZ to standardise guidelines, risk assessment, protocols and data sets.

5 Work with Osteoporosis NZ planning the Nationwide World Osteoporosis Campaign for World Osteoporosis Day in October 2016.

6 Continue with promotion of education around osteoporosis and fracture prevention.

7 Continue to promote and socialise the Fracture Liaison Service within primary care.

Measuring and monitoring performance

Total number of fragility fractures put on register who met criteria of service	***Falls prevention***	***Bone protection***	***Bone density scans***	***Exclusions*** *(did not meet the criteria of the service)*	***Review and capture***
Fragility fractures excluding hip Hip fractures Clients who deceased Deceased (hip fracture) Deceased (fragility # non-hip)	Clients referred to falls prevention Clients offered falls prevention but declined Clients accepting falls prevention who engaged for 4 month programme Falls prevention not applicable (in rest home or deceased) Clients not yet processed Clients unable to get hold of Partially processed but then transferred out	Clients on bone protection meds on admission or commenced on during admission Clients not yet processed/ difficulty contacting Referred to GP to start bone protection (by way of letter from Fracture Liaison Nurse) Client unable to get hold of or deceased Partially processed but then transferred out Started on Vit D at NDHB Started on Fosamax at NDHB	Referred for bone density scan Not applicable (technically difficult or already met the criteria for treatment, deceased) Clients not yet processed Offered but declined Client unable to get hold of	Excluded as out of town Excluded because of nature of fracture (eg bone metastases caused fracture) Excluded as transferred to another DHB	Fragility fractures Fracture Liaison Nurse reviewed and % of clients subsequently captured by service

2.5 Mental Health and Addictions Services (MHAS)

↪ NRHP Top 19 priorities, no. 8
4 Key service delivery areas \ Mental health

What outcomes are we trying to achieve?

MHAS Vision

Mental Health and Addiction Services strive to provide a service of excellence, integrating both evidenced-based clinical care and rehabilitation services.

To create an environment for Northlanders, at risk of or affected by mental health or addiction problems, to have the tools to weather adversity and to actively support each other's wellbeing and attain their potential ('Rising to the Challenge'). Recovery based values will underpin the service approach, recognising and building on people's personal strengths and resources, as well as those of their family, whanau and community.

MHAS Goals for 2016/17

Equity

To ensure that all people can access timely and appropriate mental health and addiction services in the community and as close as possible to home throughout Te Tai Tokerau.

To reduce the inequity of outcomes experienced by Maori by ensuring their access to culturally and clinically appropriate care.

To improve MHAS capacity and capability to meet the needs of older people and for people with high and complex needs.

To reduce the stigma and discrimination experienced by people with mental health and addiction problems, promoting their equitable access to the full range of health services, including physical health, education, housing and employment.

For all MHAS in Northland to become co-existing problems capable.

Early intervention

To provide early access to evidence informed, recovery focused mental health and addiction services that are close to home and integrated across different sectors, including primary, secondary and tertiary care.

To implement initiatives that will build a more coordinated web of support for young people with or at risk of developing mental health and addiction issues.

Develop an implementation plan aligned to 'support parents healthy children guidelines' (MoH, 2015), to increase the capability of adult MHAS to meet the needs of children of parents with mental illness and addictions.

Provide education and information to families and whanau about mental health and wellbeing, including information about services across the care continuum.

To have good alcohol harm data across the population for service planning and to intervene earlier in problem development.

Value for money

Aligned with the Ministry of Health new outcomes and commissioning framework and the NZ Triple Aim model, the MHAS will continuously develop services and commit resources to enable the best health outcomes to be achieved for individuals and the population, for equity to be assured and experience enhanced within the resources available.

To use all available resources (people, money, equipment, locations, other) as efficiently and effectively as possible to achieve the best possible outcomes to meet the requirement for "best value for public health system resources".

To have the right workforce in the right place at the right time, working to their scope of practice and delivering clinically excellent and effective services that are highly valued by service users and families, are highly productive and cost effective.

To ensure the acute care continuum (including IPU, crisis, DAO, sub-acute, respite, meds run) has the right model of care and capacity to efficiently and effectively meet the needs of adults, children, youth and older persons.

Explore the use of information technology, including telemedicine, as an enabler to achieve the most efficient and effective service delivery.

Integration

To improve operational integration between MHAS and NDHB hospital health services.

To improve operational integration between DHB funded mental health and addiction services with a focus on shared care planning.

To improve the operational integration between primary and secondary services and between them and other social services.

Why is this important for community and patients?

Users of MHAS have the right to receive treatment as early as possible, in the least restrictive environments, as close to home as possible, that are person centred, recovery focused, clinically

appropriate and that promote their health, autonomy and ability to live as independently as possible in the community.

Mental health and addiction problems are the cause of significant morbidity and mortality that not only affect the individual but also impact on the wellbeing of whanau.

Poor access to services, or poorly integrated services which do not provide recovery focused, clinically indicated interventions, lead to a perpetuation of serious mental health or addictions problems. This can lead to undue involvement in mental health and addictions services, and contribute to social isolation, homelessness, unemployment, or imprisonment.

Lack of timely and effective treatment for people with mental health or addictions problems can impact on their family, for example the ability to effectively parent their children.

Equity

People with mental health and addiction problems experience discrimination and prejudice which reduces their access to mental health and other health services, education, housing and employment.

People have difficulty accessing services in the community (especially rural communities), including transport problems, and often access services late.

Maori are over-represented in service users and have poorer health outcomes than the rest of the population. Service planning and delivery has to be more effective for Maori and reduce the inequity of outcomes that Maori experience.

People with severe and enduring mental health and/or addictions problems have a life expectancy 20 to 25 years lower than the general population and are at greater risk of chronic health conditions.

People 65+ have a lower level of access to MHAS, and are a rapidly growing population group who require improved access to services that will allow them to 'age in place' (2.4 Health of older people).

A minimum of fifty per cent of people with mental health or alcohol problems have co-existing problems and we need to have across sector service models and a workforce that can respond to this need.

Early intervention

Identifying unmet needs and intervening early in people's local communities will achieve better personal health, whanau and population outcomes and over time ultimately reduce the demand for more expensive and acute MHAS.

Empowering communities (for example through providing information and education), individuals and families will allow better self care, earlier access and intervention for people who are or may be experiencing mental health and addictions problems.

Young people are a high risk group for suicide, with young Maori having a higher risk of mental health and substance use problems.

Value for money

The Mental Health and Addiction Service system will need to be innovative and responsive, more efficient and effective in order to provide the right amount and quality of services, and to meet a continued growing demand for access.

The different sectors and services involved in providing mental health and addictions services will need to work in a more collaborative, connected and coordinated way.

The Mental Health and Addiction Service will need to be able to measure the effectiveness of services delivered, especially from the service user perspective, gaining timely and ongoing feedback that is used to measure and improve services.

The mental health and addiction workforce is the most critical factor in delivering services that meet needs and achieve positive outcomes for people with mental health and addiction problems. The workforce needs to have the right mix (including ethnic profile to match population), capability and capacity to meet current and future emerging needs.

Technology is an important enabler to providing safe, effective and efficient mental health and addiction services, especially in a complex system with multiple services and teams that operate 24/7, serving a widely dispersed population across a large geographical area.

Integration

Commonly, service users and whanau face barriers or confusion about how to obtain appropriate mental health or addiction assessment and treatment. This is increased when the sector is fragmented with poor communication and rigid access criteria.

Good mental health has to be everyone's business and Mental Health and Addiction Services can't do it alone. A 'whole of person – whole of government' approach is essential. We can achieve more positive and sustainable (personal, whanau and population) outcomes by having a more 'joined up' approach and partnership across different sectors and communities.

Access to the specialist input of regional services is enhanced by clear clinical pathways and regular interface meetings.

There is currently a critical need to prioritise high and complex need clients who require minimum secure residential rehabilitation.

Other critical needs include child youth acute care, older persons acute care, acute care continuum services enhancement (crisis, respite, sub-acute, meds run, intensive community team [ICT], early intervention psychosis [EIP]).

The Police are reporting significantly increased involvement and demand on their resources to respond to mental health issues in the community, and are implementing a policy where people with known or potential mental health problems will be brought directly to hospital emergency departments for assessment rather than taken to police stations.

NGOs are situated within a broader spectrum of community agencies, all of which are striving to improve social outcomes for people in their local communities. NGOs will continue to strengthen their approach to improve service user social connectedness including increasing employment, education and voluntary options. NGOs will continue to use a RBA (Results Based Accountability) framework to report status and change across a number of social determinants that include employment, smoking, housing and GP attendance.

Primary care is the first point of contact and of ongoing care. To improve service users' health it is critical that this approach continues to be strengthened, to become more 'fit for purpose' to care for people with high and low prevalence mental health and/or addiction conditions.

Specialist clinical services across the acute care continuum must be well connected and coordinated and working to a current recovery care plan for each client. Good discharge planning must be in place to ensure the timely, effective transition of clients between and across inpatient and community services.

Actions planned for 2016/17

Foundation activities

1 Create a 5 year MHAS strategic plan outlining the future vision and how this will be achieved, with active involvement and participation by staff, service users, family and whanau, NGOs, primary care and other key service stakeholders.

2 Establish an integrated across-sector (including NGO and PHO) MHAS philosophy and model of care that is recovery-oriented and outcomes-focused.

3 Establish a shared set of service values that is aligned to NDHB's and a philosophy of care across MHAS that guides service planning, delivery and decision making.

4 Establish project management capacity to allow strategic service development work to be completed and enhance the performance and sustainability of MHAS.

5 Review the MHAS clinical governance structure to strengthen the clinical and management partnership, so that it promotes the best possible service quality, service user experience and service performance.

6 Review the MHAS quality improvement and innovation group to ensure a sound quality assurance programme is in place, and that there are focused service improvement activities that change and improve service quality, safety and performance.

7 Continue to participate in Northern Region Alliance MHAS planning, funding and service development work, effectively advocating for and achieving equitable outcomes for Northland MHAS.

8 Establish a MHA services workforce development plan aligned with the five year strategic plan and vision.

9 Embed the RBA contracting framework for MHA services with NGOs using an outcomes focused approach, aligned with the MoH commissioning and outcomes framework.

10 Establish MHA service locations and facilities in the community that are accessible, functional and are safe and healthy workplace environments.

Equity

11 Make “every door is the right door” and trial a single point of entry to improve access and the efficiency and effectiveness of MHAS.

12 Implement the 'working with Maori' enabler from the Let's Get Real framework, using outcomes from the ‘Working with Maori’ Hui in August 2015, in partnership with Te Poutokomanawa and other key stakeholders.

13 As part of the ‘working with Maori’ enabler action, evaluate the Maori clinical service model (Te Roopu Whitiora) and implement a ‘kaupapa Maori’ MHA service model.

14 Develop an AOD withdrawal detox service management plan aligned with the Northern Regional Alliance plan.

15 Review options for access to hospital bed care for people with alcohol or other drug problems.

16 Workforce development planning will address co-existing problem (CEP) capability across the sector

17 MHAS will fund and participate in the annual Mental Health Awareness Week, in partnership with the Northland DHB Maori Health Team (Te Poutokomanawa), NGOs, primary care and other agencies.

18 Implement interventions that will upskill mental health and addiction nurses in physical health assessment, building on the successful pilot completed in the Far North in 2015.

19 Promote healthy lifestyles by implementing a smokefree practices programme in the inpatient unit.

20 Collaborate with Health of Older People Services to provide an integrated dementia clinical pathway.

21 Trial a clinical nurse specialist liaison role between MHAS and the residential aged care sector to reduce crises and demand for acute services, and improve care for older people with high and complex needs.

22 Plan and establish an older persons acute inpatient service for eight persons as an alternative to admission to the Tumanako acute inpatient unit.

Early intervention

23 Develop a referral pathway (in conjunction with NRA) for Autism Spectrum Disorder, Fetal Alcohol Spectrum Disorder and conduct disorder in collaboration with Child Health Services

24 Deliver more services for eating disorders, youth forensic and impaired driving, and services into correctional facilities, as per the Crown Funding Agreement.

25 Participate in evaluation of the maternal infant mental health (MIMH) and youth co-existing problem (CEP) services for future service delivery.

26 All service users will be screened for CEP and when indicated provided with a brief intervention or referred to specialist services for further assessment and treatment.

27 All funded MHAS will screen for mental health, addictions and physical health issues, and promote healthy lifestyles.

28 All service users and families will be provided with information about mental illness and addictions, MHA services, and health and wellbeing.

29 Enhanced Co-existing Problem (CEP) services within Whangarei-Kaipara and Far North through partnership between NGOs and NDHB; this includes capacity to address physical health issues.

30 Develop a Youth Participation policy and implement across CEP Youth services.

31 Improve access to CAMHS and Youth AOD services through wait time’s targets and integrated case management.

32 Improve follow up in primary care of youth aged 12-19 years discharged from secondary mental health and addiction services by providing follow-up care plans to primary providers.

33 Improve the responsiveness of primary mental health innovation and initiative services access for youth (aged 12 – 19 years).

Value for money

34 Review and apply additional FTE staff into the Whangarei Crisis Service to meet unmet need and demand.

35 Review the acute care continuum (including IPU, crisis, DAO, sub-acute, respite, meds run) for adults, children and youth and older people to develop the most effective and efficient model of care and service delivery across the district.

36 Increase the use of evidence informed group work across Mental Health and Addiction Services.

37 Measure outcomes by implementing the Health of the Nation Outcomes Scale (HoNOS), alcohol and other drugs outcome measure (ADOM) and the Real Time Consumer Feedback process, and initiate a codesign approach to service improvement.

38 Establish project management capacity to drive service change and improvement activity, including the Kei to Anga Whakamua integrated align model of care project.

39 Use PDSA to evaluate the six month partnership between primary care and specialist services to facilitate easy entry, brief intervention and discharge back to primary care within six to ten weeks, for clients with an affective disorder.

40 Develop an integrated approach to service provision for older people with mental health and substance use disorders.

41 Utilise JADE to enhance shared care planning and improve service user outcomes.

42 Establish a rationalisation of reporting project to reduce duplication by establishing one single care plan for each service user.

43 Implement a clinical dashboard reporting system to provide meaningful data that informs clinical decision making, and more efficient and effective ways of working.

44 Establish NGO RBA reporting dashboards to improve service performance.

45 Develop Implementation plan based upon formative evaluation of Exemplar Youth CEP service pilot in Whangarei-Kaipara and Far North and strengthen.

46 Establish NGO RBA reporting dashboards to measure service outcomes and improve service performance.

Integration

47 Review the location and functionality of Whangarei, Kaipara and CAMHS Community Mental Health Services and establish locations in the community that will maximise access, responsiveness and provide a safe and health workplace environment.

48 Develop a reporting mechanism from the Mental Health and Addictions Primary Care Clinical Governance into the MHAS Clinical Governance Group.

49 Northland DHB has committed to passing on any CCP increases annually to NGO and PHO funding.

50 Continue to implement the Northland DHB Te Tai Tokerau Suicide Prevention Plan 2015-17.

51 Northland DHB will establish a secure reporting database (including RBA and PRIMHD) reporting to allow across-sector data analysis for strategic and operational planning.

52 Create improved clinical care pathways for people with co-morbid medical and psychiatric needs and improve access to general hospital services for people with MHA problems.

53 Develop a crisis referral pathway between Rubicon CEP and CAMHS Te Roopu Kimiora.

54 Develop and implement a discharge planning tool for all patients admitted to the IPU.

Measuring and monitoring performance

Equity

PP7 Social indicators (employment, housing, PHO registration) (quarterly).

Number of AOD screenings of mental health clients and mental health screening of AOD clients (six-monthly).

Physical wellness checks completed and followed up for service users.

Number of staff who have completed Te Pou "Working with Maori" module (quarterly).

Number of nursing staff who have completed physical health assessment training with NorthTec (quarterly).

Mental Health Awareness Week table of events (annually in January).

Number of staff who have stopped smoking in the IPU.

Early intervention

Access rates: PP6 number of clients accessing early intervention services (Coexisting Disorders, Maternal/Infant Continuum, Impaired Driving, and Correctional Facility).

Number of people screened for co-existing problems; how many people provided with a brief intervention; how many people referred to specialist services as a percentage of the relevant cohort.

Number of people provided with information about mental illness and addictions, and about mental health and wellbeing as a percentage of the relevant cohort.

Mental health literacy levels.

Value for money

Number of participants in groups and number of groups provided (quarterly).

PP8 waiting times (quarterly).

OP1 FTE quarterly report against Price Volume Schedule.

Number of completed HoNoS, ADOM and Real Time surveys; Changes in HoNOS, ADOM scores.

Staff productivity percentage by employment group – direct client contact time for medical, nursing, allied (quarterly).

Roadmap of how the HOP Service and POPS (Psychiatric Old Peoples Service) will provide an integrated model of care.

Decrease the percentage of clients in the service for more than one year (quarterly).

Integration

PP7 recovery and transition plans on discharge for Child and Youth (quarterly).

Number of discharge plans on discharge from the acute inpatient unit.

Number of interagency meetings (such as primary care, Fusion/ CYF/ Police) quarterly.

Number of referrals from primary health (quarterly).

Number of shared care plans on JADE.

Number of service teams using clinical dashboards on daily basis.

Number of hospital staff completing MHA training sessions

Clinical care pathway described for people with comorbid medical and psychiatric needs.

Development of new protocols for improved physical care of psychiatric clients in the community setting.

2.6 Maternal and child health

↪ NRHP 4 Key service delivery areas \ Child health ↪ NRHP Top 19 priorities, nos. 2, 10

2.6.1 Maternal and child health

What outcomes are we trying to achieve?

In Northland, inequities in health outcomes are most profoundly experienced for Maori infants and children and for infants and children living in quintile 4-5 areas of Northland. Addressing these inequities is the focus of all service improvement activity across Maternal and Child Health services.

The need for a collaborative, multidisciplinary, integrated approach to the provision of services, including information sharing by professionals, is an area of focus across Maternal and Child Health services. The need to address issues impeding continuity of care, such as access, transport, and financial problems, must also be addressed.

The Caring for our Future - Child Health Service Level Alliance Team (SLAT) has identified five goals for the programme of work and areas where health gains for Maori infants and children can be made. We continue to focus on the first 2000 days (conception to 5 years).

Goal One: Children in Northland have the best start in life, beginning in pregnancy.	**Goal Two:** Children in Northland live in an environment that promotes health and development so they can reach their full potential	**Goal Three:** Children in Northland are protected from preventable and avoidable illness and injury	**Goal Four:** Children with complex health needs and disability have their support needs met	**Goal Five:** Children have access to appropriate mental health care
Pregnancies are healthy and parents are prepared.	Healthy housing, warm, dry and smokefree Homes are safe from violence, abuse and neglect Children are caries free Children are well nourished and physically active Children are protected from infectious diseases	Children are safe from injury and avoidable death, and are protected from infectious diseases, through timely completion of the well-child immunisation schedule	Coordinated care within the multidisciplinary team and across the sector Family health literacy	Whanau/ families are empowered to better manage the impacts and effects of mental health issues

Priority areas for 2016/17 are:

Improved pregnancy care. This includes timeliness of LMC engagement, early identification of issues and intervention through effective coordination that enables and encourages whanau participation through partnership with service providers.

Improved access to *antenatal education/parenting preparation*

Increasing health literacy of whanau about the *free universal health checks* and services that support healthy childhood.

Increasing health literacy of Maori whanau about importance of *nutrition and physical activity* during pregnancy and childhood.

Removing barriers to timely enrolment, engagement of whanau with child health services and completion of checks (including immunisation) for infants through systems improvement.

Improving *oral health outcomes* at age five for tamariki Maori and children living in quintile 4-5 communities

Improving completion rates for tamariki Maori and quintile 4-5 children for *B4SC*, ensuring effective care coordination where issues are identified and information sharing as appropriate during transition to school.

Improving access to *culturally competent health* care is critical to addressing health inequity for Maori whanau.

Why is this important for community and patients?

Adult health is shaped throughout the life course. Poor health outcomes early in life affect quality of life and cost of health service provision across the lifespan. There is now a huge body of international evidence to demonstrate that the period from conception through the early years of a child's life provides

the foundation for lifelong physical, social and emotional wellbeing. Nationally and internationally, there has been an increased focus on the antenatal and early life years as the time to ensure prevention of many different adverse outcomes for physical and mental health through early intervention. This is because the cognitive and physical development of infants and children is influenced by the health, nutrition, and behaviours of their mothers during pregnancy and early childhood.

Improving the health of a woman before she becomes pregnant would be an ideal. As this is difficult, early engagement with maternity care is important.

In Northland, inequities in health outcomes are most profoundly experienced for Maori infants and children. Pregnant Maori women are more likely to be younger, to smoke, to live in a deprived area, are less likely to access antenatal education and have fewer antenatal visits. Their babies are more likely to have a lower birthweight, have a SUDI, spend time in the Special Care Baby Unit and to be readmitted to hospital within the first 12 months of their life.

Medical conditions, many with a social gradient and particularly for Maori children under two years of age, make up the majority of admissions to the Child and Adolescent Inpatient Unit at Whangarei Hospital.

Actions planned for 2016/17

1 Continue with analysis of demographic information about women who book later in pregnancy with a LMC. Undertake awareness raising activities with a focus on quintile 4-5 communities and with allied service providers including pharmacy, Family Planning and youth training programmes about the importance of timeliness of LMC engagement and how to access a LMC in the community where they live.

2 Improve consistency and content of first-point-of-contact assessment in general practice when pregnancy is confirmed with the practice – particularly opportunistic screening and assessment for young Maori women, first-time mothers, and women who are known to be experiencing multiple adversities.

3 Investigate the development of an antenatal pathway within the Canterbury Health Pathways framework.

4 Continue the work of increasing health literacy for Maori whanau by improving the quality and acceptability of messages and information to pregnant women, parents with young children and their whanau, with a focus on agreed key messages (such as breastfeeding, smoking cessation, safe sleep), providing leadership and facilitation of relevant workforce training across the sector. Initiate focus groups with consumers about current resources and media used for promotion of information about breastfeeding, smoking cessation, safe sleep and immunisation. Involve consumers in codesign of any new resource development such as paracetamol harm reduction.

5 Investigate the added value of smartphone technology to increase access to information to young parents. In particular information about the free universal health services available, which commence in pregnancy and continue until the child is age five years, and links to websites that contain additional relevant information. This might include timeframed prompts to remind the caregiver that screening, milestone and development checks and immunisations are due, and local provider information and contact details (preferably direct access).

6 Continue work toward establishment of the Maternal and Child Care Coordination model, for pregnant women where issues are identified that may impact on health outcomes for both themselves and their babies.

7 Primarily this model of care seeks to reorient and enhance health and social service support services to better meet the needs of pregnant and postnatal Maori women experiencing adversities:
- early and comprehensive screening and assessment for pregnant Maori women and women birthing a Maori infant, especially those with adversities
- earlier referral of this cohort to midwives, specialist and support services (and referral back to primary care)
- kaiawhina support for pregnant Maori women to enable access to services and facilitate smooth transition of care between services, facilitate community support networks for the woman and whanau that will continue beyond engagement with the Case Management Forum and, build confidence and skills in mothercraft/ parenting
- demonstrated integration and cooperation between sectors and services. This integration should mean that the process of getting help is ‘seamless’ for the woman and her whanau.

8 Continue implementation of the Gestational Diabetes Guidelines. Continue actions toward equity of access across Northland to nutritional services, diabetes nurse specialists, ultrasound screening and post-birth follow-up.

9 Improve access to antenatal education/parenting preparation for Maori woman and whanau through adaptation and delivery of the Te Mata O Mua Kaupapa Maori antenatal programme in Whangarei and to rural communities; Kaitaia, Kaikohe and Dargaville. This is a collaborative partnership between Hauora Whanui Tamariki Ora, (Ngati Hine), NDHB Maternity and Health Promotion, Ringa Atawhai and other community based Maori NGOs.

10 Continue the current programme of systems and process improvement in newborn integrated enrolment and completion of NBHS screening, immunisation, core well child contacts 1-3 and oral health service enrolment and assessment. Continue to monitor compliance (through audit) and effectiveness (timeliness of transition of care, enrolment and completion for each event).

11 Continue our participation with the Northern Region DHB project for integrated newborn enrolment toward business case development for NCHIP and the Care Coordination model.

12 Continue the Fluoride Varnish Project Oral Health Service partnership with Raumanga Medical Centre.

13 Evaluate the effectiveness of the programme in preventing caries at five years among the eligible and participating cohort of preschoolers enrolled with Raumanga Medical Centre.

14 Evaluate the effectiveness of the current model of delivery of the B4School Check service (2.2.6 Childhood obesity) toward improvement of referral pathways, access to treatment or intervention for identified issues, and sharing of relevant information between providers concerning new entrants to school, with a focus on equity for tamariki Maori and children living in quintile 4-5 communities.

15 Evaluation and recommendations to be discussed with Caring for our Future SLAT. Action plan developed and implemented. Outcomes monitored.

16 Participate in the development of regionally consistent guidelines for B4SC providers re referral pathways for overweight and obese children. This includes:
- development of a guideline for clinical staff working in secondary and tertiary care to respond when children are found to be overweight or obese
- working with primary care to ensure growth charts consistent with the Ministry of Health's advice are being used in primary care patient management systems
- undertake a stocktake of current physical activity and nutrition programmes available in the region, and review evidence of effectiveness for such programmes (under the NHSP Fit for Life Project 2.3.1 NHSP Fit for Life – obesity).

17 Enhance and expand culturally competent service delivery models that best support families with children who are overweight or obese at B4SC toward a healthy weight (2.2.6 Childhood obesity).

18 Continue to fund and support Project Energize in participating primary schools. Extend the programme to more schools across Northland (dependent on funding).

Measuring and monitoring performance

Increase in the number and % of women registering with a LMC during first trimester (<14 weeks gestation)

Decrease in the number and % of late and unbooked women.

Decrease in number of women smoking during pregnancy.

Increase in the % of pregnant women provided with support to quit.

Decrease in number and % of women with "no GP" or inaccurate GP information at time of booking with the LMC.

Smartphone project scoping complete.

Based on outcome, proceed to development of a business case.

Total number of pregnant woman working with the Case Management Forum.

Of these women the numbers and % of infants:
- received SUDI risk assessment, whanau education about safe sleep and access to a safe sleep space where needed

- enrolled with a GP within 2 weeks of birth, receiving newborn hearing screening
- with immunisations at 6/52 and 3/12
- with well child core visits 1-3 completed
- enrolled with an oral health provider.

Number and % of women enrolled with Family Start or similar parenting programme.

Establish baseline measurement of attendance by ethnicity.

Increasing the antenatal education options for pregnant Maori women should see an Increase in the number of Maori woman attending antenatal Maori classes.

Increase in the % of Maori infants completing NBHS by 3/12 of age.

Increase in % of Maori infants receiving timely core visit one at six weeks.

Increase in number and % of Maori infants enrolled with a WCTO provider at 3/12 of age.

Increase in the number and % of all infants fully enrolled with general practice at 3/12.

Increase in number and % of Maori infants immunised at 6/52.

Increase in number and % of tamariki Maori caries free at age 5 and who have participated in the preschool Fluoride Varnish Project.

Increase in number and % of 4 year old tamariki Maori and quintile 4 and 5 with completed B4SC.

95% of Maori children overweight or obese are referred *(new Health Target).*

Number of participating schools.

Programme outcomes measurements over time.

2.6.2 Rheumatic Fever

What outcomes are we trying to achieve?

Reduce the incidence of rheumatic fever in Northland by two thirds by 2017. This means a reduction in the rate from 10.5/100,000 hospitalisations per year to 3.5/100,000, or a reduction in cases from 17 to 6 per year in Northland by 2017.

Why is this important for community and patients?

Rheumatic fever is a preventable disease which almost exclusively affects Maori. Reducing its incidence will reduce the burden of disease experienced by individuals and whanau, reduce hospitalisations and secondary prevention, and reduce the mortality and morbidity associated with the cardiac consequences of this preventable disease. It will significantly contribute towards increased life expectancy and better health outcomes for Maori in Northland.

Actions planned for 2016/17

1 Implement the refreshed Rheumatic Fever plan.

2 Provide funding investment for Rheumatic Fever prevention from July 2017 and provide an investment plan in quarter 2.

3 Engage with primary care to monitor and address disparities in access and utilisation for children under 13 years (via PHO utilisation data).

4 Support the Manawa Ora Programme to ensure all eligible children receive referrals, and these referrals are actioned in a timely manner.

5 All cases of acute and recurrent acute Rheumatic Fever are notified to the Medical Officer of Health within 7 days of hospital admission and/or when a diagnosis is confirmed; these will contain complete case information.

6 Annual audit of Rheumatic Fever will be collated and reported quarterly for secondary prohpylaxis coverage for children 0-15, youth ages 15-24 years and adults 25+ years.

7 Follow up on issues identified by the 2015/16 audit of recurrent hospitalisations of acute Rheumatic Fever and unexpected Rheumatic Heart Disease.

8 Root Cause Analysis of all rheumatic fever cases and implementation of recommendations from these reviews is supported and directed from the Rheumatic Fever Steering Group.

9 Undertake case reviews of all Rheumatic Fever cases (first episode and recurrent), address identified systems failures and report on these quarterly.

10 Implement and monitor the NDHB Communications Plan for key messages across Northland, aligning with annual national awareness campaign, and inclusive of communication promoting throat-swabbing services available during school holiday periods.

11 Work with RF providers to monitor and support health promotion of rheumatic fever and key messages.

12 Continue to implement and monitor public health nursing service opportunistic throat swabbing in schools.

Measuring and monitoring performance

Reduction of rheumatic fever by two thirds in Northland by 30 June 2017.

Reduction of rheumatic fever hospitalisation from 10.5/100,000 per year to 3.5/100,000 per year, or a reduction of cases from 17 to 6 per year in Northland by 30 June 2017.

2.6.3 Vulnerable Children

What outcomes are we trying to achieve?

Support the prevention and early identification of child maltreatment through delivering on the Children's Action Plan (CAP) and through aligned initiatives.

Provide services which contribute to infants having the highest attainable standard of health and equity of life expectancy and parents being confident, knowledgeable and supported to nurture.

Why is this important for community and patients?

Actions taken within the health sector and with organisations in other sectors will help improve outcomes and contribute to a reduction in the number of child assaults.

Actions planned for 2016/17

1 Child Protection Policy will be reviewed by July 2016 to include the new national guidelines and requirements of the Vulnerable Children's Act 2014 (see also 5.8.3 Safe and Competent Workforce).

2 Continue the focus on reducing the number of assaults on children through a range of approaches:
- ongoing evaluation and quality improvement of the VIP
- monitor the effectiveness of the NCPAS and take action to address any unintended negative consequences.
- health professionals training in recognising signs of abuse and maltreatment including partner abuse screening.

3 Implement the Children's Action Plan through:
- considering local implications of information from Children's Team
- maintaining interagency/ service governance to better safeguard vulnerable children
- scoping the development of a perinatal case management forum to increase identification during pregnancy and support lead maternity carers (LMCs) and other key workers to implement effective interventions
- expand the scope of the Current At Risk Women Register forum to include women not currently in CYFs care but who have risk factors, including mental health issues and substance use; *and* implement a case management forum for women experiencing multiple adversities in pregnancy.

4 Implement mental health initiatives including respite beds and support packages for women with maternal mental health issues (note that this is a mental health initiative).

5 Establish a baseline of women with maternal mental health and alcohol and other drug/addiction issues who utilise primary mental health services.

6 Obtain information from and consider district-wide themes and issues associated with Children's Teams demonstration sites. Decide on recommendations and implementation plan.

7 Ensure that staffing policies and procedures and contracts entered into align with the Vulnerable Children's Act.

8 Support the multidisciplinary Children's Teams.

9 Maintain the Gateway Assessment Service, including assessment of and developing multidisciplinary action plans for referred children in state care.

10 Maintain and strengthen the existing VIP champion roles within the organisation.

11 Review VIP and child abuse training to ensure compliance with national guidelines by Sep 2016.

12 Maintain and where appropriate, further develop services associated with:
- improving access to universally available health care for vulnerable children, young people and their families.
- the shaken baby programme (100% of maternity staff, including SCBU staff will be trained regarding the shaken baby programme by Jan 2017).

Measuring and monitoring performance

Increase the number of women screened for family violence and who receive appropriate follow-up compared to 2015, including by ethnicity.

Report on number of infant uplifts that occur in the maternity services, including monitoring by ethnicity.

All referred children receive a Gateway Assessment within the targeted timeframes, and monitor by ethnicity.

Number of reports of concern submitted by NDHB staff to CYF, and monitor by ethnicity.

Number of positive family violence screens, and monitor by ethnicity.

Achieve a minimum audit score of 80/100 for each of the child and partner abuse components of our VIP programme, and monitor data on ethnicity.

Maintain the National Child Protection Alert System (NCPAS).

Increase levels of staff in all screening services that have been trained in child protection and partner abuse.

Increase the number of staff trained to recognise and respond to family violence.

100% of staff carrying out partner abuse screening have completed child protection and partner abuse core training.

Increase the number of women screened during pregnancy for mental health and alcohol and other drugs in primary care sector.

Increase in the number of children identified as being at risk of maltreatment and appropriate referral made

Increase in the number of positive screens for family violence.

2.7 Youth health

↪ NRHP 4 Key service delivery areas \ Youth health

What outcomes are we trying to achieve?

Improve access, quality and outcomes and reduce inequities for youth through the delivery of evidence based, effective and integrated youth health services.

Our overarching goal is that Northland rangatahi in 2017's National Youth Health Survey are healthier than reported in previous surveys.

Why is this important for community and patients?

As a young person enters adolescence, their parents are largely responsible for their healthcare, but by the end of adolescence, most young people will have taken over responsibility for this aspect of their lives. Adolescence is a period associated with rapid physical, psychological and social development that may predispose young people to a range of health issues, and which also poses unique communication and management challenges for primary healthcare providers. The challenge for healthcare providers is to maintain effective clinical relationships while the transition occurs.[2]

The years between 12 and 24 are also those when the chances of being caught up in risk-taking behaviour are high, and where the negative consequences can be lifelong. While most young people appear to deal successfully with the developmental changes that occur during this period, there is evidence that many do not.[3]

Actions planned for 2016/17

1 Co-design an enhanced model of care for school based youth health services with a focus on integrated care supported by a shared electronic record

2 As a partner to Kaikohe Social Sector Trial Northland DHB is supporting a pilot Youth Health Assessment project in collaboration with Kaikohe Police, Ngapuhi Iwi Social Services and the Public Health Nursing Service; this is a full health screening and assessment of youth (aged 10-19 years) including AOD and mental health and physical/ medical issues to provide GPs and youth whanau with a full health assessment report.

3 PHNs will engage youth in meaningful discussions and options regarding their sexual health wellbeing.

4 PHNs will maintain their status for the provision of ECP.

5 PHNs to have a range of training opportunities in 2016/17 to enhance their skill base for working with youth.

6 Support primary care in creating a single patient record for youth health.

7 Primary care will merge all 7 youth health datasets into one (Taipa Clinic, Kaitaia Clinic, Rural Beat Clinic, Youth Space, Octane Youth Health Clinic and a number of high school datasets)

8 123 Clinic will continue to provide a full range of sexual health services in Kaikohe and Kaipara which will include the provision of LARCs at no cost to young people.

9 Focus our efforts on decile 1-3 high schools and colleges as they have the highest Maori rolls.

10 Ensure the new model of care for school based health services considers the mental health needs of students.

11 Quality improvements in school based health services will be guided by the 'Youth Health Care in Secondary Schools: A framework for continuous quality improvement' document.

12 Public Health Nurses will transition from a paper-based PMS to an electronic record that is aligned with primary care.

13 Ensure a range of psychological services is available to young people, including e-therapy.

14 Establish a workforce development plan to increase the number of clinicians in Northland who are undertaking or working towards a qualification in youth health and development.

15 Contraceptive services are now being offered at three Sexual Health Clinic sites across Northland. In addition to the doctor, Nurse-led clinics are working with Standing Orders to provide free contraception. In addition to this in 2016/17:
- of the five doctors employed, two have been trained to insert and remove Jadelle implants; by 2017 it is expected a further two doctors will be trained
- an application has been submitted to the Abortion Supervisory Committee for three of the Sexual Health doctors to become Certified Consultants; this will improve access for young women outside of Whangarei who require termination services

[2] The Health Status of Children and Young People 2011: Models of Primary Health Care Delivery for Young People.
[3] Youth Health: A Guide to Action, MoH 2002.

- a Contraceptive Nurse Training Manual is under development which will support nursing staff working to Contraceptive Standing Orders.

16 The Sexual and Reproductive Health Plan 2016-2020 has been forwarded as a draft proposal from Innovate Change to the NDHB. From here NDHB will consider the recommendations within it and the approach to be taken. It is anticipated that a small working group will be set up to develop a project plan by September 2016.

17 Work collaboratively with other regional DHBs, especially the Northern Regional Youth Health Working Group.

18 Participate in the development of the Standards for Quality Care: Adolescents and Young Adults through Regional Youth Health Working Group.

19 Develop and articulate transition pathways by service (such as mental health, alcohol and other drugs, long term conditions) from child to youth and youth to adult services.

20 Work with disability providers to ensure that the needs of our disabled youth are not neglected.

21 Support the amalgamation of Whangarei Youth Space and Octane.

22 Enhanced Co-existing Problem (CEP) services within Whangarei-Kaipara and Far North through partnership between NGOs and NDHB; this includes capacity to address physical health issues.

23 Ensure youth are considered and consulted in the development of the Northland Sexual and Reproductive Health Plan 2016.

Measuring and monitoring performance

Access

ED presentations for youth declining in 2016/17 with clinic utilisation for Whangarei Youth Space and Octane increasing.

From October 2015 (start of initiative) until October 2016 baseline data on Jadelle insertion within NDHB facilities will be collected.

Outcomes

Meet the regional target of youth (0-18 years) access to specialist drug and alcohol services of 1.5% by June 2017.

Maintain Year 9 HEADSSS assessments at contracted volumes.

Percentage of youth aged 12 to 19 discharged from CAMHS and youth AOD services into primary care being provided with follow-up care plans.

Number of Kaikohe youth who are referred for a health check from Youth Aid.

Number of additional health services accessed by Kaikohe youth as a result of the health check identifying unmet health needs as part of their Alternative Action with Youth Aid

There will be one dataset for youth who present to primary care in Northland.

Continue to reach the waiting time targets for non-urgent mental health and addiction services – 80% seen within 3 weeks, 95% within 8 weeks (including CAMHS and youth AOD services) (7 Performance measures, PP8).

Services further developed for children of parents with mental illness and addictions (COPMIA).

Northland youth suicide rate continues to decline

Increased number of youth who have never smoked.

Teenage births in 2016/17 (14-19 years) will be lower than the number of births in 2015/16.

Lower youth termination of pregnancy rate in 2016 (at or below regional average).

Improved youth health literacy, especially in how to access services.

Lower rates of school expulsions and stand downs.

Increased utilisation of oral health services by youth.

Quality

Youth would recommend services to family/whanau and their peers.

Youth would prefer to access a youth clinic instead of ED for non-emergency services.

2.8 Long term conditions

2.8.1 Diabetes

NRHP Top 19 priorities, no. 7
4 Key service delivery areas \ Diabetes

What outcomes are we trying to achieve?

We will address the inequities leading to poorer health and eliminate the disparity in health outcomes experienced by Maori impacted by diabetes.

Individuals and their whanau living with diabetes in Northland have the knowledge that they need to live well with diabetes, by understanding:

- the impact of being overweight on health and the benefits of healthy eating
- the benefit of increased regular physical activity
- what they need to know to increase self-management of their condition e.g. adherence to prescribed medication, stopping smoking.

Deliver integrated services from primary to secondary care so that individuals with diabetes receive patient-centred services that empower them to self-manage their diabetes, ensuring patients receive the right care by the right person at the right time.

Continue with and further develop the interface between primary and secondary care (e.g. through shared care records).

Why is this important for community and patients?

Current estimated data for Northland predicts that 7.5% of the adult population suffers from diabetes. Of these, 43.1% are Maori.

Current ambulatory sensitive hospitalisations (ASH) rates for diabetes in Northland demonstrate that for Maori the rate is 314 per 100,000 compared to 83 per 100,000 for non-Maori.

Type 2 diabetes is largely preventable and avoidable by making healthier life choices.

Individuals who live with diabetes are at risk of complications and poor health outcomes. Gout is one of the most common forms of acute inflammatory arthritis. It tends to occur particularly among Maori and Pacific men and in older patients on diuretic therapy. Comorbidities such as obesity, type 2 diabetes, hypertension and chronic renal disease that are associated with raised uric acid levels contribute to the increasing prevalence of gout.

Data from Northland's PHOs tells us that of the patients diagnosed with diabetes who have had a HbA1c test within the last 12 months, overall 65% had a result of 64mmols or less. By ethnicity, 45% of Maori compared to 28% of non-Maori % achieved results of 64mmols or less.

Patients diagnosed with diabetes can be managed successfully in primary care. Supporting patients and whanau to have a greater role in the management of their condition, such as by increasing their understanding of the disease to make lifestyle changes, will support them to live well with diabetes.

Having excellent links between primary and secondary care allows specialist interventions to be delivered closer to home, reducing inequities to those in rural areas and high needs groups.

Actions planned for 2016/17

1 Continue with the established primary care approach developed in "More Heart and Diabetes Checks' to maintain our current performance of 90% of the eligible population who will have had a cardiovascular disease risk assessment and diabetes check.

2 In line with Standard 4 of the 'Quality Standards of Diabetes Care Toolkit, design, develop and deliver a project to identify and provide support to individuals with poorly controlled diabetes (HbA1c

over 64mmol or with existing complications) and low to moderate mental health issues and provide them with additional support. Services and funding will be focussed on Maori patients and whanau to support the reduction of health inequities experienced by Maori with diabetes.

3 Refocus funding for the Green Prescription (GRx) service to incentivise Maori referrals, increasing access to the programme and reducing health inequities for Maori. Funding will incentivise the provider to increase the ratio of Maori referrals by 10% this year (to achieve a target of 51.9% Maori) which will require an increase in Maori numbers by 41% to achieve the target.

4 Implement systems and processes to identify prediabetes in at-risk groups and initiate plans for early intervention, ensuring community programmes are available across Northland to provide appropriate support in key areas such as management of obesity, nutritional advice and support with physical activity (Green Prescriptions).

5 Ensure that primary care continues to target at-risk populations to perform checks for diabetes in Maori patients and achieve 90% checks in this high-risk group.

6 Continue to deliver the “Stop Gout” programme in partnership with community pharmacies in Northland which currently targets Maori patients, and where possible (subject to funding) expand the programme.

7 Monitor and provide feedback on current medical management of diabetes against best practice guidelines including triple therapy, prescribing of statins and ACE inhibitors, recognition and treatment of chronic renal disease.

8 Work to ensure sustainable funding to continue to deliver the podiatry programme across Northland, increasing early detection and intervention for foot problems and providing access to subsidised primary podiatry services.

9 Continuously evaluate, develop and promote patient self-management programmes, ensuring that these are accessible and culturally appropriate to Maori patients.

10 Continue to develop a method to count the enrolled people aged 15-74 in the PHOs with diabetes and the most recent HbA1c during the past 12 months of equal to or less than 64 mmol/mol, equal to or less than 80mmol/mol or equal to or less than 100mmol/mol and greater than 100mmol/mol).

11 Trial telehealth services between Whangarei Hospital and general practices in the Far North to allow greater access to specialist advice and knowledge in primary care through the use of telehealth conferences.

Measuring and monitoring performance

Maintaining 90% of diabetes checks in eligible populations.

GRx will support at least 2,011 (51.9%) Maori individuals by June 2017.

A new pilot service will be implemented that targets Maori patients who have been identified as having poorly controlled diabetes (over 64mmols) and low to moderate mental health patients. Outcomes will be tracked for progress towards improvement in diabetes control and self-reported improvement in mental wellbeing.

Achieving the goal of 90% of eligible Maori patients receiving heart and diabetes checks.

Reduced gap in the diabetes ASH rate for Maori compared to non-Maori.

Gout and podiatry initiatives data will demonstrate improved outcomes for patients, particularly for Maori.

Establishment of a mechanism to identify and report the number of patients with HbA1c of above 64, 80 and 100mmols, including the ability to identify patient ethnicity.

Evaluate the telehealth case conference pilot between Whangarei Hospital and primary care general practices in the Far North.

2.8.2 Cardiovascular disease

↪ NRHP 4 Key service delivery areas \ Cardiovascular services

What outcomes are we trying to achieve?

Address the inequities experienced by Maori men and women who disproportionately suffer from cardiovascular disease in Northland and die earlier than non-Maori.

Identify and diagnose individuals at risk of CVD to enable early treatment to slow progression, reduce the impact and improve the quality of life for those diagnosed.

Individuals who have diagnosed CVD will receive high quality care where possible closer to home, and be able to safely and confidently self-manage their condition.

Health services for people with CVD will be high-quality, patient-focussed and integrated across the health continuum from prevention to tertiary care.

Why is this important for community and patients?

Life expectancy for all Northlanders is lower than the national average. Maori men and women's life expectancy in Tai Tokerau is 9 years less than non-Maori.

Incidence and impact of cardiovascular disease can be prevented through improving health literacy, reducing the burden of comorbidities and risk of premature death.

Ambulatory sensitive hospitalisations (ASH) in Northland are higher than the national average, with rates for CVD related incidence the highest of all the conditions. The inequity suffered by Maori is substantial, with a total ASH rate combined for all CVD conditions of 7,752 per 100,000 population. For non-Maori the ASH rate combined for all CVD conditions is 3,389 per 100,000 population.

Managing CVD within a primary care setting reduces the burden on secondary care and means that patients and whanau can receive care closer to home, reducing the need to travel to Whangarei Hospital.

Actions planned for 2016/17

1 Continue to implement Cardiovascular Disease Action plans within each general practice to ensure that 90% of the eligible population receive a CVD risk assessment. Ensure that activity and plans are targeting Maori patients – including opportunistic assessment.

2 Continue to proactively identify and offer to eligible Maori men between 35-44 years a CVD risk assessment.

3 Subject to funding, invest and increase the resources of Northland's Primary Options (2.3.3 Primary Options) service to provide additional interventions to CVD patients so that they can receive treatment closer to home; within Primary Options, target Maori patients.

4 Apply the Equity of Health Care for Maori framework to ensure that resources are focussed at eliminating inequities.

5 Continue to fully utilise the Green Prescriptions volumes, ensuring that they are culturally accessible for Maori, achieving a 10% increase in Maori participants.

6 Continue to deliver and expand where possible kaupapa Maori self-management modules for disease-specific education.

7 Trial telehealth services between Whangarei Hospital and general practices in the Far North to allow greater access to specialist advice and knowledge in primary care.

Measuring and monitoring performance

Maintain 90% of eligible population receiving a CVD risk assessment.

Achieve 91% of eligible high needs population receiving a CVD risk assessment.

Monitor Green Prescription volumes, including seeing a 10% increase in Maori participation from 2014/15.

Primary Options to increase Maori referrals by 10% from 2014/15.

Evaluation of the telehealth trial on cases presented from primary care to secondary care with a focus on CVD patients.

2.8.3 Cardiac services

NRHP Top 19 priorities, no. 5
4 Key service delivery areas \ Cardiovascular services

Cardiac rehabilitation is one of three priorities for the Alliance Leadership Team (the others are 2.3.1 NHSP Fit for Life – obesity and 2.3.8 Rural SLAT).

What outcomes are we trying to achieve?

We want to provide a cardiology service which is clinically effective, strives for excellence with equitable access for our population. We want to enhance our patients' experience and ensure our services meet their needs with a focus upon the hard-to-reach population with the greatest need.

Why is this important for community and patients?

Cardiovascular diseases (CVD) remain the leading cause of death within Northland, accounting between 35% and 40% of all deaths. The prevalence of ischaemic heart disease is higher in Northland than in New Zealand; and the disease burden falls disproportionally on Maori who represent 31.5% of the population. This is more than double that of New Zealand as a whole (31.5% compared to 14.6%). It is important to address this disparity to ensure that our population has equal access and equal health benefits from our service.

Actions planned for 2016/17

1 Contribute data to the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of Acute Coronary Syndrome (ACS) risk stratification and time to appropriate intervention.

2 Improve completeion and timeliness of ANZACS-QI data by developing a process to ensure the remaining data inputted via our local Cath lab is completed within 30 days.

3 Work with the regional, and where appropriate, the national cardiac networks to improve outcomes for ACS patients and for patients with heart failure.

4 Review and audit Accelerated Chest Pain Pathways (ACPPs) in Emergency Departments by end of Q2.

5 Deliver a minimum target intervention rate for cardiac surgery, set in conjunction with the National Cardiac Surgery Clinical Network, to improve equity of access.

6 Ensure appropriate access to cardiac diagnostics to facilitate appropriate treatment referrals, including angiography, echocardiograms, exercise tolerance tests etc.

7 Manage waiting times for cardiac services, so that patients wait no longer than four months for first specialist assessment or treatment.

8 Continue to review and develop ACS pathways which include autonomous paramedic prehospital thrombolysis programme, percutaneous revascularisation and prompt coronary angiography.

9 Implement changes following a Northland DHB external cardiology review which include workforce development, expanding nurse-led initiatives, cardiology ambulatory services improvement programme and demand and capacity planning.

10 Implement the redesigned cardiac rehabilitation/ high risk prevention programme (2015/16), targeting those most at risk, reducing the burden of heart disease in Northland communities by improving the equitable uptake of lifelong heart modification and lifestyle changes.

11 Review, audit and develop strategies to improve access for Maori and other high risk groups. This includes more effective use of available data within the ANZACS-QI database.

Measuring and monitoring performance

Acute Cardiac Services

PP20: 70% of patients will receive an angiogram within 3 days of admission ('day of admission' being 'day 0') reported by ethnicity.

Secondary Services

PP29: Improved access to diagnostics. 95% of people will receive elective coronary angiograms within 90 days

Elective Services Patient Flow Indicators: patients wait no longer than four months for first specialist assessment and treatment.

95% of echos to be completed within 4 months of referral.

SI4: Standardised Intervention Rates.

Cardiac surgery: a target intervention rate of 6.5 per 10,000 of population will be achieved. DHBs with rates of 6.5 per 10,000 or above in previous years will be required to maintain this rate.

Percutaneous revascularisation: a target rate of at least 12.5 per 10,000 of population will be achieved.

Coronary angiography: a target rate of at least 34.7 per 10,000 of population will be achieved.

Cardiac Rehabilitation/ High Risk Prevention Programme.

95% of those with high risk unstable heart disease have a patient and whanau centred MDT transitional care plan, supporting their transition from acute hospital care to primary and community based cardiac rehabilitation and secondary prevention.

Cardiac Rehabilitation data collection and analysis; ANZAC Q1 reporting and;.

- number and percentage of patient referrals to community based cardiac rehabilitation/high risk prevention programmes: by level of risk, locality, ethnicity (annual baseline of approximately750)
- 60% of patients are participating (uptake) in cardiac rehabilitation/ high risk prevention programmes (baselines to be established by ethnicity, locality and type of programme)
- mortality benefits (outcomes) NHI analysis (national and regional project phase 2).

2.8.4 Stroke

↪ NRHP Top 19 priorities, no. 9
4 Key service delivery areas \ Stroke

What outcomes are we trying to achieve?

Improving stroke prevention, and reducing stroke-related disability and mortality.

Ensuring people with stroke have access to quality-assured thrombolysis service 24/7.

Ensuring people with stroke receive early active rehabilitation by an interdisciplinary stroke team.

Ensuring equitable access to community stroke services.

Support of and participation in, Northern Regional clinical stroke network.

Why is this important for community and patients?

Stroke is the third leading cause of death in New Zealand and second leading cause of severe disability in adults. It disproportionately affects Maori (occurs younger and is more severe). Hence we aim to provide services to reduce the burden of stroke to individuals, their whanau and the community.

Actions planned for 2016/17

1 Support any public education campaigns about stroke, such as Face, Arm, Speech, Time (FAST).

2 Increase the numbers of stroke patients receiving quality thrombolysis service.

3 Work with the Northern Region ratification of the hyper-acute stroke pathway and implementation plan.

4 Complete and implement changes to existing community A&R programmes to improve flow of patients from inpatient to community environments, completing a hospital-to-home rehabilitation pathway by quarter 3 (inpatient and community stroke rehabilitation is not age-related).

5 Respond to recommendations from the National Stroke Network.

6 NDHB is fully participating with the national thrombolysis register.

Measuring and monitoring performance

PP20 eligible stroke patients thrombolysed: target 6%

PP 20 rate of acute stroke admissions to ASU: target 80%.

PP 20 time to transfer to inpatient rehabilitation: target 80% within 7 days.

Documented hospital to home rehabilitation pathway by Q3.

2.9 Whanau Ora

↪ NRHP 2 Northern Region Context \ Drivers for change \ Outcomes and inequalities
3 Our direction \ N. Region Future Landscape \ Improving health gains for Maori

What outcomes are we trying to achieve?

Achieve Whanau Ora by focussing on accelerating Maori health gain in the five health priority areas:

- mental health: reducing the rate of Maori committed to compulsory treatment order relative to non-Maori
- tobacco: better support for pregnant women to quit smoking
- asthma: reduce asthma admission rates for Maori and Pacific children
- oral health: Maori and Pacific 5-year-old children are caries free
- obesity: Maori children are receiving B4 School checks

Supporting Maori whanau to choose the quality services they want, when they require them.

Eliminate inequities in health outcomes for Maori in Te Tai Tokerau.

Why is this important for community and patients?

Northland DHB is committed to eliminating inequities and improving Maori health gain. Why? Because it is unacceptable that Maori whanau in Northland should die nine years earlier than non-Maori.

Equity of health outcomes aims to ensure that quality care is available to all and that the quality of care provided does not differ by race, ethnicity, or other personal characteristics unrelated to a patient's reason for seeking care.

Actions planned for 2016/17

1 Maintain iwi and Whanau Ora Collectives' contribution to planning processes, decision making about services, and monitoring performance and equitable outcomes for Maori.

2 Regularly communicate at a regional level through the Regional GM Maori network and Tumu Whakarae with appropriate agencies to identify opportunities to support Whanau Ora providers and collectives in Te Tai Tokerau by strengthening Maori workforce capability and capacity, including Maori in health planning and using supporting data on needs and service utilisation in service delivery and design. Support agreed joint initiatives to galvanise collective impact to support the achievement of outcomes for whanau.

3 Whanau Ora Collectives and providers support Maori whanau to navigate systems within health and social sector to ensure they receive quality services, particularly in the 5 key areas of mental health, asthma, oral health, obesity and tobacco in primary.

4 Utilise the 'Health Equity Assessment Tool' and 'Equity of Health Care for Maori: a Framework' as training tools, socialise the importance of eliminating inequities in Te Tai Tokerau and improve primary care to work more effectively with Maori whanau.

5 Ensure Maori health care workforce are accessing the HWNZ non-regulated workforce training fund to build capability and capacity.

6 Te Roopu Kai Hapai Oranga (Northland Alliance Leadership Team) commit to collective decisions to dedicate resources and effort to Maori whanau in:
- reducing smoking rates
- improving healthy lifestyles initiatives (obesity).
- asthma care planning in primary care

- Maori children receiving quality B4 school checks
- reducing the rate of Maori committed to community treatment orders

7 Ethnicity data analysis of the 5 key areas will be provided to NDHB Executive Leadership Team to address ongoing inequities.

8 Quality Improvement Directorate provides qualitative data on patient and whanau satisfaction with health services.

9 Strengthen our relationship with Te Pou Matakana Commissioning agency through quarterly meetings to provide update on planning and commissioning activities and to identify opportunities for joint activities that will benefit whanau in Te Tai Tokerau – Q1-Q4.

10 Identify collaborative opportunities to work with Te Pou Matakana and Pasifika Futures to co-invest and co-design services that contribute to increasing whanau ora health and social outcomes – Q2 and Q4.

11 Identify one commissioning priority in the Te Tai Tokerau that Northland DHB and Te Pou Matakana can invest in jointly that will benefit whanau – Q2.

Measuring and monitoring performance

Monitoring performance in the Trendly, Maori Health Performance Monitoring Tool every quarter.

Utilisation of all allocated HWNZ monies, by Dec 2015.

Reprioritise funding and resources to reducing inequities in the 5 key areas

Trending quarterly and 6 monthly data in the 5 key areas are demonstrating a reduction in disparities between Maori and non-Maori for:

- mental health: reducing the rate of Maori committed to compulsory treatment orders relative to non-Maori
- tobacco: 95% of all pregnant women to be smokefree at two weeks postnatal
- asthma: reduce asthma and wheeze admission rates for Maori children (ASH ages 0-4)
- oral health: increase the number of Maori children are caries-free at age five
- obesity: by Dec 2017, 95% of obese Maori children identified in the B4 school check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

Monitoring performance of DHB services to reduce inequities through service reports when available, quarterly to 6 months.

Training on eliminating inequities is delivered to staff, and` leads to more effective service delivery to Maori as demonstrated through patient/ whanau satisfaction survey and improved access to services, by June 2017.

2.10 Oral health

↪ NRHP 4 Key service delivery areas \ Child health

What outcomes are we trying to achieve?

Provide high-quality oral health services that promote, improve, maintain and restore good oral health, and that are proactive in addressing the needs of those at greatest risk of poor oral health.

Why is this important for community and patients?

The inequalities that exist in the health status of people living in Northland, particularly Maori and those living in poorer, rural communities, impact directly on their oral health. Lack of fluoridation of the water supply further compounds the impact of deprivation on the oral health status of Northland communities.

The Northland Health Services Plan (NHSP) embodies Northland DHB's strategic intentions toward addressing the inequalities that exist in the health status for people living in Northland, and incorporates the national and regional health priorities set by the Ministry of Health.

As an indicator of general health status, improving the oral health status of Northlanders, particularly Maori, is a priority. He Mangai Hauora mo te Waka a Taonui (the Maori Health Gains Council to the Northland DHB) has identified oral health as one of the five areas of priority for action.

Despite the intensive efforts and gains made, approximately 65% of Northlands children experience at least one or more decayed teeth by the age of 5. Many vulnerable adults on low incomes in Northland continue to experience difficulty accessing affordable oral health care Dental services for low income adults with a Community Service Card are provided in Whangarei, Kaitaia, Kaikohe, Hokianga, Dargaville and the Whangaroa area. These service are provided by Ngati Hine Health Trust, Northland DHB and a private practitioner.

Some of the major concerns in oral health in Northland are:

- high dental admission rates in the ambulatory sensitive hospitalisations data for the period 2008–201 among Northland children aged 0 to 14
- high dental caries rates (the highest in the country) among 5-year-olds and Year 8 children in Northland
- oral health inequities (between Maori and non-Maori) seen in the oral health status of children and adults in Northland
- low adolescent utilisation rates of community oral health services compared with the national average
- increasing oral health needs of low-income adults (who access community oral health services)
- increasing rates of access to secondary clinical services (hospital dental services) by older people

Actions planned for 2016/17

1 Continue to increase preschool and adolescent enrolments.

2 Ensure every child and adolescent in Northland is seen annually, with a move to progressing to see every high risk child every six months.

Measuring and monitoring performance

85% of eligible preschool population to be enrolled with a public oral health provider

85% of eligible adolescent population to be enrolled with a private or public oral health provider.

90% of children and adolescents to be seen annually.

Reduce number of treatment visits per child from 2.5 to 1.5 for each course of treatment.

2.12 Diagnostic waiting times

What outcomes are we trying to achieve?

Radiology

Imaging services for screening, diagnosis and treatment rationalise the need for clinical interventions and help target them where they will have the greatest benefit. They achieve this by providing diagnostic information at critical points in the patient journey, and the option of image-guided minimally invasive interventional procedures. Interventional radiology procedures allow minimally invasive procedures to be performed and often avoid the need for more invasive surgery.

Work differently, particularly in providing high tech, high cost imaging services (such as CT and MRI), given the current tight fiscal environment.

Adequately staff imaging services, especially in key areas where there are significant workforce shortages.

Colonoscopy

Position our services in readiness for the national bowel screening programme by achieving waiting time targets for colonoscopy. A national bowel screening programme will be introduced at a future date, though details and timing are yet to be determined by MoH.

Why is this important for community and patients?

In Northland the age-standardised rate of cancer registrations 2010-2012 was 342 per 100,000, higher than the Northern Region (Waitemata 327, Auckland 331, Counties Manukau 331) and New Zealand (338).

In Northland the age-standardised rate of cancer mortality 2010-2012 was 143 per 100,000, higher than the Northern Region (Waitemata 113, Auckland 113, Counties Manukau 128) and New Zealand (126).

Improving diagnostic waiting times (radiology and colonoscopy) continue to be a priority for the Government.

Achieving equitable and timely access to high quality imaging, matching capacity to demand and maximising productivity should support NDHB to provide a local high quality, timely and efficient service for both patients and healthcare colleagues.

Actions planned for 2016/17

Colonoscopy

1 Reduce colonoscopy wait times to the level required by the Ministry of Health indicators consistent with national indicator timeframes:
   - urgent diagnostic colonoscopy: 85% within 14 days and 100% within 30 days
   - diagnostic colonoscopy: 70% of people will receive their procedure within 42 days, 100% within 90 days
   - colonoscopy surveillance: 70% within 84 days and 100% within 120 days.

2 Work with the Northern Regional Alliance to develop a colonoscopy plan that identifies facility and workforce requirements to meet forecast demand. NDHB will subsequently participate in developing business cases which may be at either regional or DHB level).

3 Support NDHB involvement in a regional nurse endoscopist training programme.

Radiology

4 Reduce CT and MRI wait times to the level required by the Ministry of Health indicators:
   - 95% of accepted referrals for CT scans will receive their scan within 42 days
   - 85% of accepted referrals for MRI scans will receive their scan within 42 days.

5 Follow regionally agreed radiology protocols.

6 Measure and monitor performance.

7 Provide monthly reports on the diagnostic indicators and targets (CT, CT colonoscopy, MRI, and colonoscopy).

8 Coronary angiography for NDHB patients is delivered and reported by ADHB.

9 Capture diagnostic tests for national Patient Flow phase three.

10 Work with regional and national clinical groups to contribute to the development of improvement programmes.

11 Work with local teams to develop actions for the management of resources, referral growth, pathways, workforce and capacity planning.

Measuring and monitoring performance

Provide monthly reports on the diagnostic indicators and targets (CT, MRI, CT colonography and colonoscopy).

Reduce colonoscopy wait times to the level required by Ministry indicators consistent with national indicator timeframes (within 14 days for urgent and 42 days for non-urgent, and within 120 days for colonoscopy surveillance).

2.13 Quality and safety

↪ NRHP 2 Northern Region Context \ Drivers for change \ Quality and patient safety
3 Our direction \ N. Region Future Landscape \ Patient participation and engagement in health improvement

What outcomes are we trying to achieve?

For us to become an organisation that delivers high quality care to everyone, every time, we need to embrace a culture of providing continuous quality improvement. This means doing the right thing, at the right time, in the right way, for the right person at the lowest cost and getting the best possible result.

Why is this important for community and patients?

There are ever increasing expectations on healthcare providers to deliver high quality, safe care. There are also increased expectations from patients and family involved in care, and transparency when things go wrong. It is evident that with this vastly changing focus and vision we need to be equipped to deliver these expectations.

Actions planned for 2016/17

1 Identify opportunities from the 'at the bedside' patient surveys to improve care.

2 Develop and improve the functionality of the Reportable Events Committee.

3 Promote the 'lessons learnt' from adverse events.

4 Implement training in root cause analysis and London protocol.

5 Develop an education package on complaint management and resolution.

6 Improve ethnicity data collection in patient surveys.

7 Increase the response rate to the national electronic inpatient survey.

8 Continue to support the national mortality and morbidity review.

SSIs

9 Continue to examine our surgical site infection results, identify ways of improving quality and safety and implement appropriate actions.

10 NDHB strives to meet the QSM targets with regular review of the programme, analysis of data and NDHB measurement/ achievement of QSM thresholds. Improvements have been steadily made each reporting period with the aim of reaching the QSM targets consistently. commitment to meet and/or sustain achievement at or above the identified QSM threshold for the clinical interventions specified by the Surgical Site Infection Improvement Programme, and that they are being adhered to in all hip and knee / cardiac operations.

11 Action is taken, as soon as practical, when a breech in recommended antibiotic prophylaxis dosing, timing and post-operative prescribing occurs. The Anaesthetic Department has requested notification if a breech is related to prophylaxis dosing or timing while the prescribing house officer is notified for post-operative prescribing breech.

12 Skin antisepsis has always been at 100% so no further action has been required to date. Correct skin antisepsis is well embedded in the operating theatres. Continual monitoring, on a daily basis when data forms are collected, of all the recommendations ensure prompt action is taken when necessary.

13 A NDHB ICP will take part in the HQSC/ ACC improvement programme.

14 Commitment to examining results and taking action to improve quality and safety.

Falls

15 All patients over the age of 75 (55 for Maori and PI) will have a falls risk assessment completed.
- Electronic risk assessments will be rolled out on Trendcare across all inpatient areas by the end of 2017. Pilot area is demonstrating 100% completion of risk assessments.

16 All patients over the age of 75 (55 for Maori and PI) who are assessed as high risk for falls will have an individualised care plan addressing the risks identified on trendcare by the end of 2017.

17 Reduce secondary hip fractures presenting to the Emergency Department by 20% by:
- case finding all patients presenting with fragility fracture to Whangarei Hospital
  - Fracture Liaison Service collect data and report on fragility fractures
  - referring clients to falls prevention programme and bone protection programme.

18 NDHB will work in collaboration with ACC on a community falls prevention programme.

19 NDHB will have a clinical pathway for the frail elderly developed by HOP service Clinical Head of Department.

20 Each month NDHB-wide, including # liaison service, falls data will be analysed at the Falls Prevention Group meeting and recommendations reported to CNM meetings.
- Serious adverse falls resulting in a fracture have a full investigation with recommendations for improvement accepted by the service. Actions will be followed up 3 monthly until change is sustained.
- Quarterly QSM results for falls will be sent to individual inpatient areas for analysis and actions reported back to Falls Prevention Group.
- Falls champions will have access to data on the Intranet for their areas in order to champion and support front line ownership of issues identified.

Hand hygiene

21 Commitment to meet and/or sustain achievement at or above the identified QSM threshold for hand hygiene compliance.

22 Hand hygiene auditor training days are held yearly to train auditors and replace auditors with an aim to promote good hand hygiene practice messages to staff, patients and visitors.

23 Results are reviewed monthly and education is provided to areas with low compliance rates.

24 Specific actions to implement related improvements, such as implementing local improvement methodology and front-line ownership.

Medication safety

25 NDHB successfully implemented electronic medicines reconciliation at admission in 2014 and is one of the few DHBs managing to report QSM data to HQSC. Electronic medicine reconciliation is available to all areas of the DHB, though it is used most consistently in those areas with allocated pharmacist resource. Plans for 2016/17 are to continue with the current targets and ensure ongoing training of new staff in this process.

26 NDHB carried out a successful pilot trial of a pharmacist-led discharge service (which included discharge reconciliation) on the medical wards in 2015. Plans for 2016 are to establish an 'end-to-end' pharmacist service for high-risk patients on medical wards which will include both admission and discharge medicine reconciliation.

Safe surgery

NDHB is in the first cohort of DHBs to implement safe surgery initiatives.

27 Continue to use the surgical checklist in paperless form as a teamwork and communication tool, rather than an audit tool.

28 All three parts (sign in, time out and sign out) of the surgical safety checklist are used in 100% of surgical procedures, with levels of team engagement with the checklist at 5 or above, as measured by the 7-point Likert scale, 95% of the time.

29 Commitment to working with the Commission to continue to implement briefing and debriefing for each theatre list by June 2017.

Reducing harm (including pressure injury (PI) prevention)

30 Adverse event reporting system asks the reporter if ACC 45 has been completed; this 'forcing function' has been in place for 18 months.

31 Serious adverse event investigations are now formalised and recommendation followed up after 3 months and one year to check sustainability.

32 VTE prevention programme continues and there is a sustained reduction from base line.

33 Clinical Audit programme is being utilised well by junior doctors and a process for reviewing outcomes is now in development.

34 PI programme continues at NDHB and will be linking with the new ACC and HQCS PI Programme. Triangulation of PI data continues to ensure robust measurement processes are in place. Daily reporting is monitored via the NDHB reporting system Datix.

35 Tracer audits are now part of normal practices. A core group has been trained in this methodology and internal documentation of staff and patients has been developed. A schedule is in place to cover key areas throughout the organisation.

36 CRAB has been introduced to look at clinical indicators and a benchmark group has been convened, led by the CMO.

37 Safety Thermometer has been tested in district nursing and worked well. With the support of HQSC this will continue in the community setting.

38 Medication safety has worked, with HQSC on the opioid project.

Promoting consumer engagement

39 Continue the Patient and Whānau Centred Care (PWCC) programme, including the Consumer Council. The Northland Health Consumer Council has been in operation for 18 months and represents the voice of consumers in service planning, design and delivery. It currently has a membership of 11 people who represent a range of ethnic backgrounds and interest areas including Māori health, Pacific health, mental health, people with long term conditions, older people, youth, women, men, rural communities and people with physical and intellectual disabilities.

40 NDHB will establish a dedicated role within the Patient Safety and Quality Improvement Directorate to manage the programme of work that contributes to patient and whanau centred care and better patient experiences.

41 We will continue to expand the patient experience surveys, including real-time feedback and post-discharge surveys, across the organisation and ensure individual wards and departments have a mechanism to share feedback received.

Building quality improvement capability and clinical leadership

42 Quality Accounts have now become business as usual at NDHB; their key focus remains patient safety and quality improvement.

43 Improvement Science information and templates are now available on the Quality Directorate Intranet page.

44 Quality improvement workshops are held with the support of HQSC.

45 Commitment to maintain the necessary infrastructure to support patient safety initiatives at the local level.

46 Commitment to report in Quality Accounts how you build capability for quality improvement and patient safety.

47 Commitment to promote online quality improvement tools and methodologies to staff.

48 Clinical leaders have attended several programme developed by HQSC. The CMO has a forum for House Officer quality improvement discussions.

49 Commitment to implement distributive clinical leadership, facilitate this by a clinical leadership programme, and report on this in your quality account.

50 Patient safety key messages are rotated systematically throughout the organisation, often with a key theme (eg June is ‘Speak up for patient safety’). This is a dedicated poster, organisational video and a grand round. In September the organisation will participate in the National Patient Safety Week run by HQSC.

51 Commitment to promote key messages and the theme of Patient Safety Week 2016.

Publishing annual quality accounts

52 A monthly Quality and Safety Report is sent to the Board. This includes, but not limited to, two patient stories, one demonstrating a good experience, one demonstrating a not so good experience. Reported adverse events, complaints, compliments all reported by SPC charts and responses from our ‘at the bedside’ survey (also in SPC).

Working with the Northern Region

53 A new regional team has been developed which will replace FDNH. The representatives come from the four Northern DHBs and is chaired by the CMO CMDHB. A plan is currently underway.

54 Two staff from this team will attend the regional workshop being hosted by HQSC in June.

Measuring and monitoring performance

Falls: 90% of older patients are given a falls risk assessment.

Falls: 98% of older patients assessed as at risk of falling receive an individualised care plan addressing the risks identified.

Hand hygiene: 80% compliance with good hand hygiene practice.

Safe surgery: a new marker measuring the use of the checklist as a teamwork and communication tool will be in use from 1 July 2016. This marker will be finalised by February 2016

SSI: 95% of hip and knee replacement patients receive cefazolin ≥ 2g or cefuroxime ≥ 1.5g as surgical prophylaxis.

SSI: 100% of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision.

Medication Safety: implementation of the electronic medicine reconciliation platform.

Staff and patient surveys will be conducted pre and post the PWCC programme.

Pressure injuries: 100% compliance to the pressure Injury prevalence audit completed monthly by the PI champions in each ward.

2.14 Living within our means

↪ NRHP 2 Northern Region Context \ Drivers for change \ Managing growth \ Financial sustainability

What outcomes are we trying to achieve?

Wisely use our resources and ensure that we are producing and getting value for money, consistent with the NHSP's aim of financial sustainability.

Why is this important for community and patients?

NDHB continues to experience cost pressures and volume growth that are endemic in the health sector. It is critical that we continue to strive to make cost efficiencies to meet the volume cost growth and continue to deliver value-for-money services to our community and patients.

Actions planned for 2016/17

1 Continued participation in the NZ Health Partnerships Limited Finance Procurement Supply Chain programme including the National Procurement Programme that commenced in 2014.

2 Commitment to the implementation of the NZ Health Partnerships Limited National Infrastructure Platform (NIP).

3 Continued participation in the NZ Health Partnerships Limited banking and insurance programme.

4 Working actively with healthAlliance to agree and deliver supply chains savings, including a reduction in the central stores footprint and moving to the Onelink supply chain.

5 Renegotiate and rationalise leased property costs and maximise utilisation of owned NDHB property stock.

6 Value-for-money reviews including community pharmacy and laboratory utilisation, patient transport services, NGO performance.

7 Deliver on directorate savings plans within DHB-owned services.

8 Review subcontracted services e.g. Food and Cleaning Services.

9 Operational Excellence – improving productivity in outpatient and operating theatres.

Measuring and monitoring performance

Forecast budgetary benefits from these initiatives will be built into the 2016/17 budget and monitored on a monthly basis to ensure that we are achieving the required cost efficiency gains as this will enable us to continue to provide financially sustainable healthcare services to our community and patients.

2.15 Information technology

↪ NRHP 5 Enablers \ Information systems

What outcomes are we trying to achieve?

Optimise the resources invested in IT.

Build an IT infrastructure which supports right place right time clinical decision-making and enables responsiveness to change.

Increase the integration of Northland's clinical information systems.

Why is this important for community and patients?

More integrated care, that is closer to home will be enabled.

Limited health resources can be focused on planning and providing care.

Access to the right care will be quicker and safer.

Actions planned for 2016/17

1 Offer patient portal to all general practices.

2 Complete upgrade to hospital Patient Administration System.

3 Implement a tactical Hospital Emergency Department Information System.

4 Complete implementation of enabling platforms for mobile applications.

5 Complete upgrade of hospital clinical portal (Concerto).

6 Undertake Phase I of Electronic Ordering.

7 Commence development of business case for electronic prescribing and administration.

8 Continue trial and implementation of electronic tools to support Neighbourhood Healthcare Homes programme.

9 Participate in national and Northern integrated Region Electronic Health Record (EHR) planning.

10 Develop asset management plan for all of Northland's health information systems.

11 Contribute to regional work on major trauma by collecting and submitting data to the national registry.

Measuring and monitoring performance

Over 80% of the Northland population to have access to a GPs patient portal by August 2016.

New Patient Administration System installed by April 2017.

Tactical ED Information System implemented by October 2016.

First mobile clinical applications deployed to handheld devices during 2016.

Phase I of Electronic Ordering commenced by March 2017.

2.16 National Entities

This section lists National Entities, their initiatives and the extent of Northland DHB's commitment to each one.

Entity	Initiative	Northland DHB's commitment
Health Shared Services	Finance, Procurement and Supply Chain (FPSC)	Commit resources to the implementation of NZ Health Partnership's FPSC initiative, and fully factor in expected budget benefit impacts.
	National Infrastructure Platform	Commit resources to the implementation of NZ Health Partnership's FPSC initiative, and fully factor in expected budget benefit impacts.
National Health Promotion Agency (HPA)	Campaign support for Health Targets	Support national health promotion activities around the Health Targets.
	Alcohol Pregnancy and Alcohol Screening and Brief Intervention	Support work undertaken by the HPA to reduce alcohol consumption during pregnancy, including, for example: • encouraging primary and secondary care health professionals to engage with and support alcohol and pregnancy initiatives • working with HPA to identify and support innovative local practice that supports women to reduce alcohol consumption during pregnancy. Relevant DHBs will support alcohol screening and brief intervention.
HQSC	Surgical Site Infection Programme (SSIP) – National Infection Surveillance Data Warehouse	Meet infection control expectations in accordance with Operational Policy Framework section 9.8.
	Surgical Site Infection Programme (SSIP) – DHB Infections Management systems (ICNet NG system)	Continue development of infection management systems at our local DHB level.
	National inpatient patient experience survey and reporting system – patient experience indicators	Survey patient experience of the care they received using the national core survey, at least quarterly.
	Capability and leadership	Meet expectations in accordance with Operational Policy Framework sections 9.3 & 9.4.6.
	Primary care – patient experience survey and reporting system	Linkages to IPIF. This initiative funded directly by MoH for 3 year period, so no DHB financial implications.
Health Workforce NZ	Increasing the number of sonographers	Address key workforce requirements with respect to the sonography workforce (NDHB is increasing our numbers from 1 to 2).
	Expanding the role of nurse practitioners, clinical nurse specialists and palliative care nurses	Support the regional approach to expanding the role of nurse practitioners, clinical nurse specialists and palliative care nurses.
	Create new nurse specialist palliative care educator and support roles	Support the regional approach to implementing nurse specialist palliative care educator and support roles.
	Expanding the role of specialist	Support the regional approach to expanding the role

Entity	Initiative	Northland DHB's commitment
	nurses to perform colonoscopies	of specialist nurses to perform colonoscopies.
	Increasing the number of medical physicists	Support the regional approach to addressing key workforce requirements with regard to the medical physicist workforce.
	Increasing the number of medical community based training places and providing access to primary care and/or community settings for prevocational trainees	Support the regional approach to providing access to community-based placements.
National Health Information Technology Board	Replacement of legacy patient administration systems	Implement a supported Patient Administration System (PAS) in alignment with the regional plan. The PAS will be implemented at our DHB by end of FY 2015/16.
	National Patient Flow	Collect Phase 2 information from July 2015. NDHB plans to provide agreed Phase 3 data from July 2016, subject to discussion and agreement once the specifications are issued.
National Health Committee		Engage with the Ministry on the work programme of the former National Health Committee (once the programme is confirmed.
Pharmac	Hospital medical devices – Pharmac procurement activity	Continue to support PHARMAC's national contracting activity for hospital medical devices. This includes committing to implement new national medical device contracts, when appropriate and assisting with product evaluations where possible.
		Support effective implementation of any product standardisation undertaken by PHARMAC during 2016/17.

2.17 Healthy Families

↪ NRHP 3 Our direction \ N. Region Future Landscape \ Maturing partnerships

Objectives of Healthy Families Far North include encouraging New Zealand families to live healthy, active lives, by making good food choices, being physically active, sustaining a healthy weight, being smokefree and moderating alcohol consumption.

Northland's Health Alliance Leadership Team has a priority focus on obesity and in 2015 initiated a piece of work to address the obesity epidemic in Northland. Through the Fit for Life (FFL) project (2.3.1 NHSP Fit for Life – obesity) a thorough and collaborative process was followed which resulted in a Tai Tokerau Childhood Obesity Prevention Framework.

We share similar objectives to Healthy Families Far North, which presents a beneficial opportunity for us to work together, support and learn from each other. Healthy Families Far North are key stakeholders for us and we have ensured engagement since the outset of the Fit for Life project. Planning for the delivery of initiatives is well underway and we are committed to supporting Healthy Familes Far North.

The inaugural meeting of the Healthy Families Far North leadership group is scheduled in July, with Northland DHB's Chief Executive invited to participate as a member. We are committed to supporting Healthy Families Far North at both strategic management and operational levels. We will do this by:

- participating in leadership arrangements at a senior executive level through our Lead GM (General Manager for Child, Youth, Maternal, Public and Oral Health Services) or Chief Executive

- NDHB planning and funding staff will continue to meet regularly with Healthy Families Far North to establish how we can support each other and align our work (for example, by continuing to meet with Healthy Families Far North health promotion staff to find synergies)
- maintain NDHB"s Healthy Lifestyles Team Leader, Public Health'sliaison with the Healthy Families Far North team
- work with Healthy Families Far North in relation to work in school settings on fizzy drinks and 'water is the best drink'
- our Health Promoting Schools Far North Facilitator has met with Healthy Families Far North, who will be attending a working group formed in the mid north comprising Health Promoting Schools, Te Hau Ora O Ngapuhi and Project Energize to coordinate work in school settings
- through this engagement and supporting Healthy Families Far North, our aim will be to agree on initiatives on which we can collaborate to improve health outcomes for our population.

Northland DHB will complete an exception report in Q4 against the plans for participation outlined above.

2.18 Intersectoral action

↪ NRHP 3 Our direction \ Northern Region Future Landscape \ Maturing partnerships

What outcomes are we trying to achieve?

Otangarei

Assist the Otangarei community "to promote and influence our multicultural community through activities and facilities that focus on family orientated community development".[4]

Social Wellbeing Governance Group (SWGG) and Children's Teams (which sit under SWGG):

More effectively respond to the challenges facing vulnerable children, youth and families in Northland.

SWGG provides overall leadership and oversight to inter-agency responses and agreed strategies that impact on the social wellbeing of children, youth and their families. Its membership includes NDHB, Police, MSD and its agencies, Tai Tokerau Iwi, Ministry of Education, Te Puni Kokiri and the Regional Children's Director. SWGG's focus is on suicide prevention, the Whangarei Children's Team, Family violence, the Kaikohe Social Sector trial, and Place based Social Investment strategies.

Social Investment aims to:

Improve the lives of New Zealanders by applying rigorous and evidence-based investment practices to social services.

Use information and technology to better understand the people who need public services and what works, and then adjust services accordingly. What is learnt through this process informs the next set of investment decisions.

Social Investment is a "place based" Treasury-led programme that looks at people in a specific geographic area who rely on public services. It uses information collected from different agencies in the public sector to better understand their needs and the types of services they receive. It uses that information to set clear, measurable goals and systematically measure the effectiveness of services. Funding will be moved to the most effective services, irrespective of whether they are provided by government or non-government agencies.

Northland Intersectoral Forum (NIF):

Working together for the wellbeing of Northlanders across four outcome areas:
- Ora (safe and healthy)
- Kaitiakitanga (guardian of the environment)
- Whanaungatanga (socially connected)
- Rangatiratanga (prosperous and economically secure).

Social Sector Trials (Kaikohe Youth Health Trial):

Identify any health, behavioural or developmental concerns that may adversely affect a young person's quality of life and general functioning.

[4] Te Hau Awhiowhio o Otangarei Trust statement.

Enable young people to improve their quality of life and general functioning across a broad range of areas such as school performance, family function and peer relationships.

Why is this important for community and patients?

Otangarei:

Substance abuse is linked to higher rates of mental health diagnosis; the number of MSD clients in Otangarei with non-specific mental health conditions is significant.

Many MSD clients with drug use and addiction issues receive reduction, suspension or cancellation of their benefit or face barriers to entering employment or training programmes. Rather than be required to undertake a six-week recompliance programme, the proposal is that they undertake brief interventions, counselling or other drug and alcohol intervention programmes.

The project should reduce the number of Otangarei residents on benefits, increase the number who are employed and improve their health outcomes.

Otangarei is a suburb of Whangarei. The project is still being drafted and discussed, and is yet to be formally approved or funded. The Otangarei Village Plan (Otangarei Kainga Ora) involves a number of Government, sports, spiritual and community agencies "to promote and influence our multicultural community through activities and facilities that focus on family orientated community development". Te Hau Awhiowhio o Otangarei Trust, within their Emerging Whanau Ora Framework, are exploring opportunities for transformational change to break the poverty cycle, improve the wellbeing of whanau and create a community of hope.

Social Wellbeing Governance Group and Children's Team:

"Vulnerable children are… at significant risk of harm to their wellbeing now and into the future as a consequence of the environment in which they are being raised and, in some cases, due to their own complex needs. Environmental factors that influence child vulnerability include not having their basic emotional, physical, social, developmental and/or cultural needs met at home or in their wider community."[5]

Vulnerable children and youth typically have lower educational attainment, poorer health and higher rates of crime. They and their families are high users of health and social services and have higher rates of benefit use. "…a large proportion of the costs to government of healthcare and social care, income support, corrections services and police services are linked to these disadvantaged individuals and families".[6]

Social Investment:

- focuses on vulnerable or high-risk groups.
- invests up-front to support people most at risk of poor outcomes later on in life.
- encourages government agencies to work with iwi, community and providers to deliver a joined-up response to overcome barriers to social, educational, economic and community success
- establish a single, shared set of outcomes to set the focus and priority across the social, educational and economic spheres
- works with local organisations to commission services within communities.
- aims to produce new citizen-centred services that cut across existing departmental service channels.
- will interact with each household through a single trusted relationship.

NIF:

NIF improves integrated planning and collaborative action between local and central government agencies in Northland.

The inclusion of both local and central government organisations provides a rich ground for increasing understanding and finding ways of working together through collective impact. The relationships built filter throughout the various organisations to improve collaboration at every level to improve the wellbeing of Northlanders.

Social Sector Trials (Kaikohe Youth Health Trial)

[5] White Paper for Vulnerable Children, NZ Government 2012.
[6] More Effective Social Services: Summary Version; NZ Productivity Commission, Sep 2015.

Unrecognised and untreated health conditions, mental health and alcohol and drug use issues are significant drivers of crime for youth in Kaikohe.

We will be better able to meet these needs if we reduce fragmentation of youth services and better integrate the work of the Kaikohe Social Sector Trial with the wider health sector.

Actions planned for 2016/17

Otangarei:

1 Work with MSD and other organisations in providing the following as part of the wider Otangarei project:
- programme management capability to progress short-medium term initiatives in the Otangarei Community Development plan
- support to specific community initiatives that will build protective factors for the individual and in the wider community to support and maintain change through, for example, healthy active lifestyles, social capital and community connections
- work with Work and Income clients who either have recorded or suspected mental health or substance abuse issues, to provide intensive case management to move them into or towards employment, and involve them in the development of specific activities associated with the community development plan
- appropriate bundles of care through existing provision and purchase of additional service to meet need; in Northland DHB's case these include time-limited psychological interventions (such as cognitive/behavioural theory) for mild to moderate issues such as anxiety, depression and post-traumatic stress disorder.

Social Investment (under the Social Wellbeing Governance Group):

2 Work with the Social Wellbeing Governance Group to design a model for an integrated place-based approach to social investment in Northland. The model will: provide immediate triage and response to at-risk children and young people and their families; use information to identify, prioritise and target those most at risk; identify longer-term investment in change, including changes to contracts.

Children's Team:

3 Support the Whangarei Children's Team to achieve the target of 233 active cases within a timeframe to be decided by the Minister of Social Development.

NIF (Ora outcome only):

4 Implement a youth suicide prevention plan for Northland.

5 Develop a family violence prevention plan for Northland.

6 Promote all NIF members to have Smoke-free and Healthy Food and Beverage Policies

Social Sector Trials (Kaikohe Youth Health Trial):

7 Work with our local Lead and other key stakeholders to develop and agree a transition plan by 31 July 2016

8 Support implementation of the transition plan.

Measuring and monitoring performance

Otangarei:
- 20% reduction in youth and adults accessing Northland DHB MHAS
- 30% reduction in young adults accessing medically deferred benefits
- 30% increase in adults returning to work following illness.

NIF (Ora outcome only):
- suicide rates
- recorded crime and family violence rates
- obesity rates
- smoking rates.

2.19 Regional activity

↪ NRHP 4 Key service delivery areas \ Major trauma

Northland DHB is involved in numerous workstreams and other activities with the other Northern Region DHBs and the Northern Regional Alliance.

NDHB commits to continue working with the Northern Region to develop hepatitis C services that are integrated across the region. We will work with the Northern Region to develop a clinical pathway, service delivery options, and an implementation plan.

We will continue to contribute to regional work on major trauma (2.15 Information technology, action 11).

NDHB continues its participation in the Northern surpra-regional spinal cord service.

3 Statement of Performance Expectations

The section fulfils Northland DHB's obligation under the Crown Entities Act 2004 to supply measures by which our future performance can be measured by the Office of the Auditor General. Together with modules 1, 4 and 7, it comprises our Statement of Intent.

The Statement of Performance Expectations (SPE) tells our 'performance story' – what we are producing (outputs) and what this is trying to achieve (impacts and outcomes). The SPE highlights a few cornerstone measures that are representative of the wide range of services for which Northland DHB is responsible. There is considerable overlap between the SPE's outputs and measures and those in Annual Plan module 2; the latter is prepared in response to a specific list of national priorities, while the SPE takes a higher level, more strategic view. The SPE is aligned with the Northland Health Services Plan (1.3 Strategic Intentions).

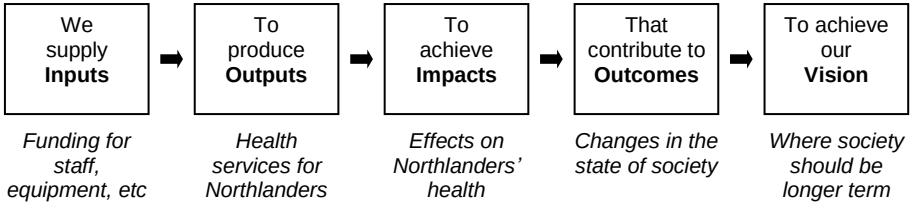
3.1 Output classes and intervention logic

Services are grouped into four output classes:

Prevention	Publicly funded services that protect and promote health across the whole population or particular sub-groups of the population. These services improve the health status of the population, as distinct from curative services (the other three output classes) which repair or support illness or injury.
Early detection and management	Commonly referred to as 'primary' or 'community' services, those that people can access directly in the community. They are delivered by a range of agencies including general practice, Maori health providers, pharmacies, and oral health services. The services are generalist (non-specialist) in nature, and similar types of services are usually delivered in numerous locations across the community.
Intensive assessment and treatment	Complex, specialist services delivered by a range of health workers, commonly referred to as 'secondary' or 'hospital' services. They include emergency department, inpatient, outpatient, daypatient, and diagnostic services. They are accessible only by referral from a primary health practitioner and available in few locations.
Rehabilitation and support	Services for older people (home based support services, residential care and services for dementia) and palliative care services.

Sections 3.2 to 3.5 address each output class in turn. The key elements are summarised in the diagram on the next page.

The Statement of Service Performance is structured according to the following intervention logic.



The Impacts contribute to the High-level Measures. For example, higher rates of cessation among smokers and immunisation among children help create a healthy population. Screening for cancers, cardiovascular disease and diabetes prevent illness and disease. Early identification and treatment of cancers and cardiovascular disease, and effective mental health services create good quality of life for people with long term conditions. Home and community support services help older people remain independent in the community, and residential care services offer the best quality of life for those no longer able to manage on their own.

Together the Impacts and Outcomes contribute to the High-level Outcomes, which are consistent with the Triple Aim of the Northland Health Services Plan (NHSP). Wherever possible, Impacts are measured by Maori and non-Maori so we can monitor inequities and reduce these over time (the Population Health aim). Quality services that are clinically and culturally safe, and provided in a timely manner encourage people to attend and be involved in their care, and that means better health status (the Patient Experience aim). To cope with ever-rising demands on services and to free up resources for new models of care and other innovations, we must continue to improve productivity and prioritise resources to their most cost-effective uses (the Value and Sustainability aim).

Summary of Northland DHB's Statement of Performance Expectations 2016/17

Vision	A healthier Northland									
High-level Outcomes	Population health: improved health of Northlanders and reduced health inequities		Patient experience: patients and whanau experience clinically and culturally safe, good quality, effective, efficient and timely care			Value and sustainability: the Northland health system lives within available funding by improving productivity and prioritising resources to their most cost-effective uses				
High-level Measures	Life expectancy gap between Maori and non-Maori ↓ by 2 years	↓ gaps between: (a) Maori and non-Maori (b) Northland and NZ	↓ mortality rate (age-standardised)	↓ infant mortality	Unplanned hospital admissions for Northlanders are reduced by 2,000 annually by 2017			>95% of patients report they would recommend the service provided		
Outcomes	Healthy population	Prevention of illness and disease	Reversal of acute conditions		Optimum quality of life for those with long term conditions			Independence for those with impairments or disability support needs		
Impacts	**Smoking cessation** Lower prevalence of smoking-related conditions	**Healthy children** Children are healthy from birth and have a healthy foundation for adulthood	**Effective primary care** People manage in the community through effective primary care services	**Long term conditions** Amelioration of disease symptoms and/or delay in their onset	**Cancer** If curable, increased likelihood of survival; if incurable, reduced severity of symptoms	**Mental disorders** Improved quality of life for both clients and their families Acute episodes are minimised, clients achieve greater stability in their condition	**Elective surgery** Fewer debilitating conditions and delayed onset of long term conditions	**ED waiting times** More timely assessment, referral and treatment	**Quality and safety** More satisfied patients Fewer adverse clinical events Lower rates of acute readmission to hospital	**Support for older people** Older people requiring support or care receive services appropriate to their needs.
Impact Measures	Year 10 students who have never smoked Adults who are current smokers	Full and exclusive breastfeeding at 6 weeks 8-month-olds who are fully immunised Average number of decayed, missing or filled teeth in Y8 students	Ambulatory sensitive hospitalisations, rate/1000 ages 0-4, 45-64	Good blood sugar management in diabetics Eligible people receiving CVD risk assessment in the last 5 years	Breast cancer screening in eligible populations Cervical cancer screening in eligible populations Urgently referred patients with a high suspicion of cancer who receive their first cancer treatment within 62 days	% of people with enduring mental illness aged 20-64 who are seen over a year	Increase in elective surgical discharges	ED patients with length of stay less than 6 hours	Falls causing harm in NDHB facilities Pressure injuries in NDHB facilities Surgical checklist compliance Hand hygiene compliance Medicines reconciled % of acute patients readmitted to NDHB hospitals within 28 days	HCSS clients assessed using interRai tool HCSS providers certified ARRC providers with at least 3 years certification
Output Classes	**Prevention**		**Early detection and management**		**Intensive assessment and treatment**				**Rehabilitation and support**	
Outputs	Health promotion programmes in schools through Smokefree/ Auahi Kore Advice and help offered to smokers in primary care Quit Card Providers Advice and help offered to smokers in hospital	Midwifery services Support by lactation consultants Oral health assessment and treatment Assessment, diagnosis, treatment and immunisations in primary care	Acute hospital services	Assessment, diagnosis and treatment in primary care Assessment, diagnosis and treatment in hospital	Screening for breast and cervical cancers Cancer risk assessments in primary care Provision of cancer therapies	Specialised clinical support by NDHB community mental health services Admission to hospital for those whose condition is acutely unwell	Elective surgical procedures	Assessments, treatments and referrals performed in EDs	Leadership, advice and monitoring by the Chief Medical Advisor and Quality Resource Unit Effective clinical services, especially for long term conditions Patient pathways, hospital discharge processes Integration between secondary and primary services	Home based support services Residential care Work with providers on corrective action plans resulting from audit
Output Measures	Health promotion in schools Advice to students re stopping smoking % of smokers given advice and help to quit in primary care and in hospital	Support provided to mothers to breastfeed Lactation consultant contacts Immunisations by 8 months Oral health treatments for Y8 students Visits by children and youth to primary care	Acute hospital admissions	Risk assessments performed on people with diabetes and/or CVD Lab tests on people with diabetes Admissions and readmissions to hospital	Screening for breast and cervical cancer in eligible populations Radiation treatments Chemotherapy treatments	Contacts by community mental health workers with people who have enduring mental illness	Additional elective procedures	Emergency department attendances	Measures of the quality and safety of services	Assessments by NASC service Certification audits

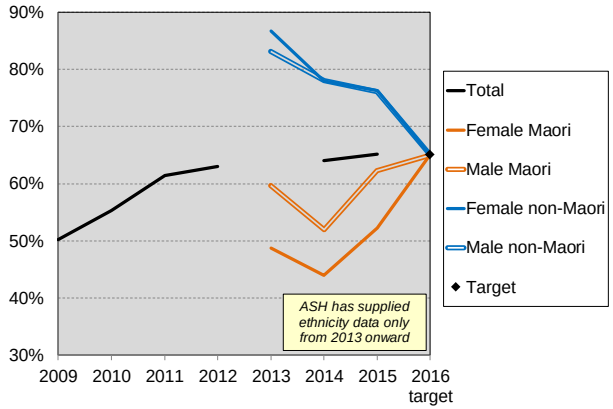
Key: Underlines = main measures. Yellow highlights = Health Targets. All measures to be by Maori and non-Maori where data is available.

3.2 Output Class: Prevention

Outcome: Healthy population

Impact: Lower prevalence of smoking-related conditions.

Measure: % of Year 10 students who have never smoked.



Measure type: Coverage

Rationale

Smoking is one of the most significant lifestyle factors behind long term conditions.

It disproportionately affects Maori and other deprived populations (the 2011-14 NZ Health Survey showed that in Northland 41% of Maori smoke and 18% of non-Maori).

Smoking during pregnancy accounts for an estimated 20% of all pre-term births and 35% of low birthweight babies.

Lower smoking rates at young ages should translate into lower smoking rates in the population in the future.

Smoking rates are the focus of one of the six national Health Targets.

New Zealand has committed to a goal of reducing smoking rates to 5% by 2025.

Outputs

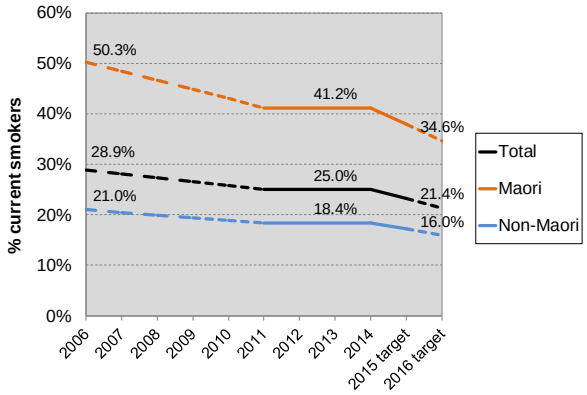
105,189 people who have ever smoked recorded in primary care, of whom 24,017 are current smokers, 23,135 were offered brief advice, and 7,671 were offered cessation support (as at 2015/16 Q3).

1187 individual quit providers registered as at Sept 2015.

Number of schools health promotion programmes are offered to, 2015 CY: 146.

Total students advised about stopping smoking 2015 CY: 800.

Measure: % of Northland adult population who are current smokers



Measure type: Coverage

Notes about the data

Y10. Examination of the long term trend suggests that the big increase in never-smokers in 2013 was a 'blip'. The target for 2015 has been set with this assumption in mind.

Current adult smokers. NZ's target is to reduce smoking rates to 5% by 2025. Targets have been set on this basis, assuming straight-line progress until 2025.

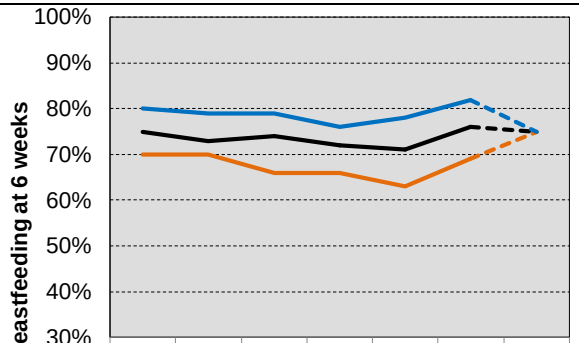
This data is from MoH's NZ Health Survey, in which multiple years are amalgamated to boost sample sizes for mid-sized DHBs. Surveys were held in 2006 and 2011-2014, hence the flat line for the latter. It will not be possible to know for sure from this source what progress we are making until another national health survey is undertaken.

We can however gain an indication of progress from primary care Health Target data, which suggests that numbers are gradually dropping, from 24.5% in 2013/14 to 23.7% in 2014/15 and 23.0% 2015/16 to quarter three. No ethnic breakdown is available from this data.

Impact: Children are healthy from birth and have a healthy foundation for adulthood

Measure: Full and exclusive breastfeeding at 6 weeks

Measure type: Coverage



	2010/11	2011/12	2012/13	2013/14	2014/15	2015-16 Jul-Dec	2016 CY target
Total	75%	73%	74%	72%	71%	76%	75%
Maori	70%	70%	66%	66%	63%	69%	75%
Other	80%	79%	79%	76%	78%	82%	75%

Rationale

Higher rates of breastfeeding in infancy correlate with a lower chance later in life of developing health problems, including long term conditions.

Breastfeeding rates are lower among Maori.

A higher percentage of the child population is Maori, so improving child health will have a significant effect on improving the health of Maori.

The target used is the national one, though Northland has been out-performing that for non-Maori and the total population.

Outputs

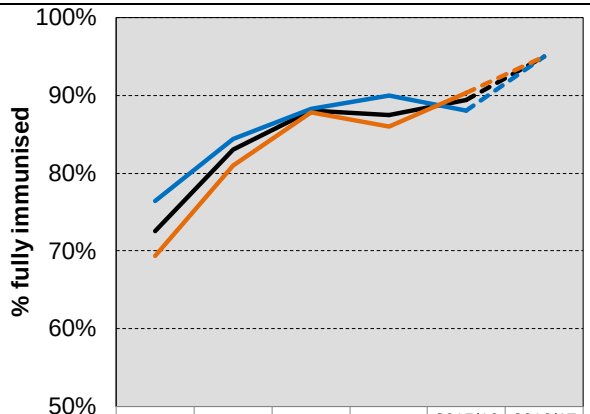
Mothers are provided with education and support to encourage them to breastfeed, whether they are supported by an NDHB midwife (hospital births) or an independent midwife (home and hospital births).

Total NDHB hospital births 1,824 for the twelve months ending March 2016.

2,953 lactation consultant patient contacts for the twelve months ending March 2016.

Measure: % of 8-month-olds who are fully immunised

Measure type: Coverage



	2011/12	2012/13	2013/14	2014/15	2015/16 to Q3	2016/17 target
Total	72.5%	83.0%	88.0%	87.5%	89.4%	95.0%
Non-Maori	76.4%	84.4%	88.3%	90.0%	88.1%	95.0%
Maori	69.3%	81.0%	87.9%	86.0%	90.4%	95.0%

Rationale

Improved immunisation coverage leads directly to reduced rates of vaccine-preventable (communicable) disease, and that means better health and independence for children and longer and healthier lives.

Immunisations are one of the most cost-effective ways of improving health.

One of the six national Health Targets.

Encouraging higher attendance rates and early enrolment in primary care will raise immunisation coverage. The High Five Project as part of the First 2000 Days Project aims to have all newborns enrolled in five key services: general practice, National Immunisation Register, Well Child/ Tamariki Ora provider, oral health, Newborn Hearing Screening.

Outputs

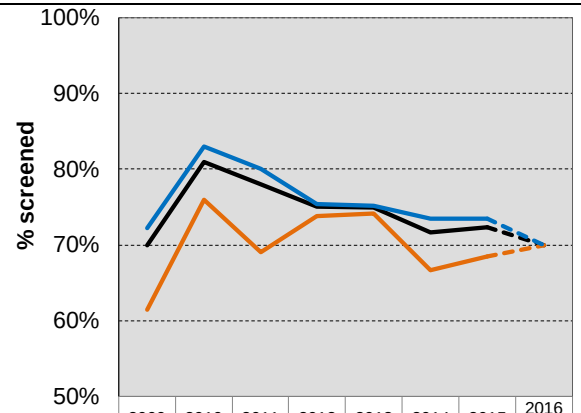
NDHB works with primary care providers to continue to improve the rate and timeliness of immunisation.

2,029 children were immunised before 8 months of age during the twelve months ending March 2016.

Impact: If curable, increased likelihood of survival; if incurable, reduced severity of symptoms

Measure: Breast cancer screening in eligible populations

Measure type: Coverage



	2009	2010	2011	2012	2013	2014	2015	2016 target
Total	70.0%	81.0%	78.0%	75.1%	74.9%	71.7%	72.3%	70.0%
Maori	61.4%	76.0%	69.0%	73.8%	74.2%	66.7%	68.5%	70.0%
Non-Maori	72.2%	83.0%	80.0%	75.4%	75.2%	73.5%	73.5%	70.0%

Rationale

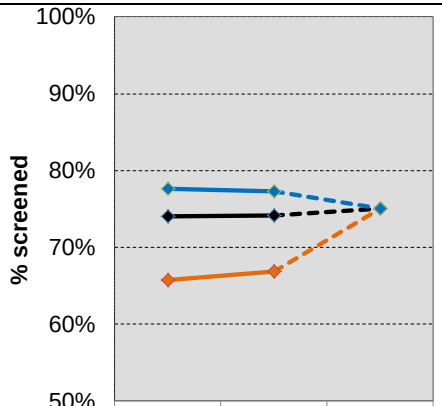
Screening in the community to identify cancers as early as possible improves the chances of prevention or, if the condition already exists, recovery. The only two formal screening programmes that exist in New Zealand are for breast and cervical cancer.

Outputs

10,733 Northland women were screened in CY 2015, including 2,334 Maori and 8,399 non-Maori.

Measure: Cervical cancer screening in eligible populations

Measure type: Coverage



	Dec 2015	Mar 2016	Target 2016/17
Total	74.0%	74.1%	75.0%
Maori	65.7%	66.8%	75.0%
Non-Maori	77.6%	77.3%	75.0%

Outputs

31,109 eligible women (aged 25-69) screened in the three years up to Mar 2016.

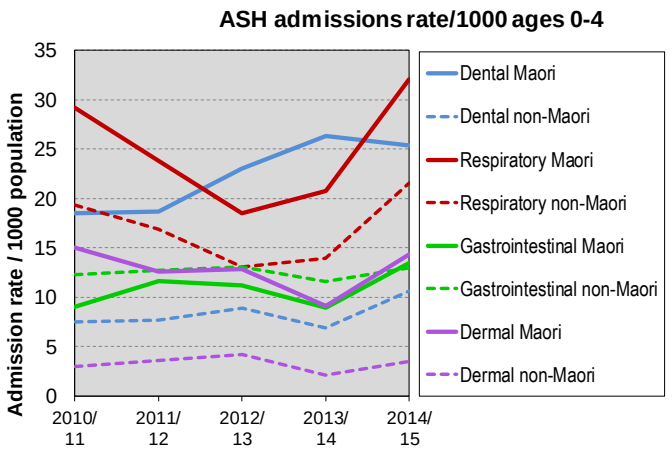
3.3 Output Class: Early Detection and Management

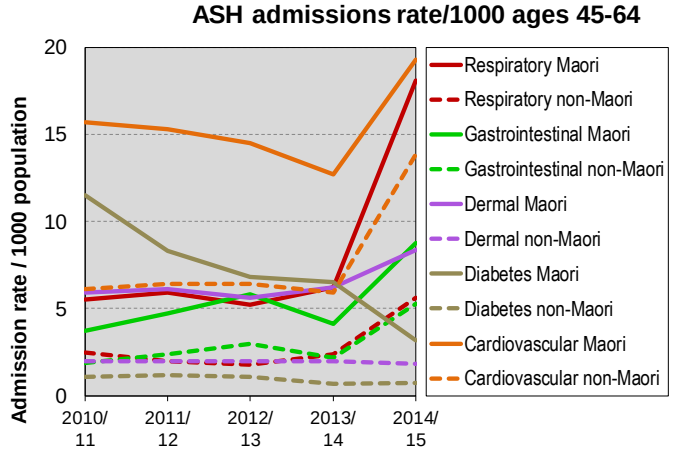
Impact: People manage in the community through effective primary care services

Measure:

Ambulatory sensitive hospitalisation rate, ages 0-4, 45-64

Measure type:
Quality





Rationale

Effective primary care services either cure conditions or keep them under control. Ambulatory sensitive hospitalisations are those which could have been avoided if patients had accessed primary care services and those services had performed effectively.

A substantial proportion of hospitalisations are ambulatory sensitive; lower rates free up specialist hospital resources for more acute and urgent cases, thus achieving better value for money from the health dollar .

ASH rates affect Maori inequitably (with the exception of gastrointestinal for ages 0-4).

Managing the interface between primary and hospital services is key to reducing ASH rates. For example NDHB's e-Referral initiative has created more prompt and effective communication between hospital specialists and GPs, enabling the latter to be better informed so they can manage more patients in the community.

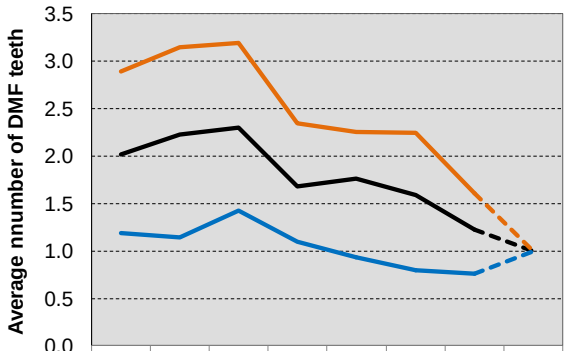
Outputs

Total acute discharges of Northland residents from any hospital (NDHB and other DHBs) 2014/15: Total 27,900, Maori 10,322, non-Maori 17,579.

Impact: Children are healthy from birth and have a healthy foundation for adulthood

Measure: Average number of decayed, missing or filled teeth in Y8 students

Measure type:



	2009	2010	2011	2012	2013	2014	2015	2016 target
Total	2.02	2.23	2.30	1.68	1.76	1.59	1.23	1.00
Maori	2.89	3.15	3.19	2.35	2.26	2.25	1.61	1.00
Non-Maori	1.19	1.14	1.43	1.10	0.94	0.80	0.76	1.00

Rationale

Oral health directly affects the state of health of the mouth, and the effects of tooth and gum disease can be lifelong. Significant rates of disease also limit what children can eat, affect self-image and confidence, and create pain and discomfort.

For many years Northland had among the worst oral health statistics for children, though significant improvements have been achieved in the last three years especially.

Northland remains unfluoridated after a brief foray into reticulated fluoridation in two Far North communities was abandoned in 2009. Northland will always struggle to reach the oral health status of DHBs that have fluoridated water supplies.

Outputs

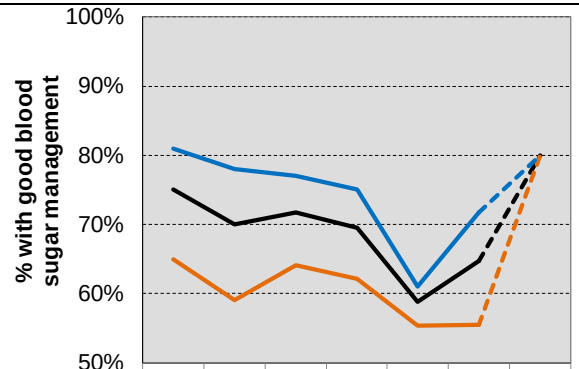
Procedures in NDHB-funded oral health services :

- 12,455 preschool (2015 CY)
- 45,579 primary school children (2015 CY)
- 1,258 adolescents treated by NDHB's services in the 2015 CY.

Impact: Amelioration of long term condition disease symptoms and/or delay in their onset

Measure: Good blood sugar management in diabetics

Measure type: Coverage



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 target
Total	75.0%	70.0%	71.7%	69.5%	58.8%	64.7%	80.0%
Maori	65.0%	59.0%	64.1%	62.2%	55.4%	55.5%	80.0%
Non-Maori	81.0%	78.0%	77.0%	75.1%	61.1%	71.7%	80.0%

Rationale

Diabetes is an increasingly common long term condition.

It is strongly associated with excess weight, which affects a disproportionate number of Northlanders. Prevalence also increases with age, so prompt action is imperative in the face of the ageing population.

It is a major cause of illness and a significant contributor to cardiovascular disease *(see below)*.

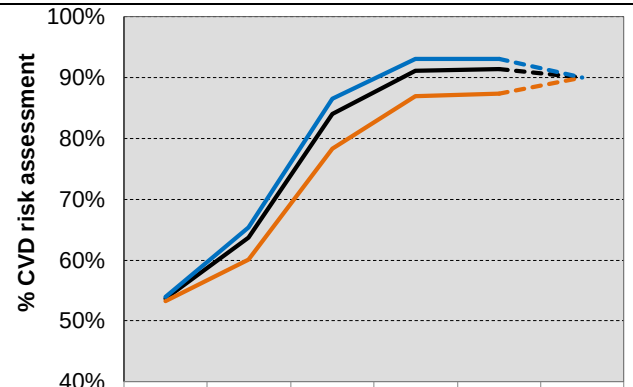
Although incurable, the effect of diabetes on daily life can be minimised through early detection, regular (annual) checks, good clinical management and a healthy lifestyle.

Outputs

4,799 diabetes annual reviews were performed in primary care in the twelve months ending Mar 2016.

Measure:
Eligible people receiving cardio-vascular (CVD) risk assessment in the last 5 years

Measure type:
Coverage



	2011/12	2012/13	2013/14	2014/15	2015/16 to Q3	2016/17 target
Total	53.7%	63.7%	84.1%	91.2%	91.4%	90.0%
Maori	53.2%	60.0%	78.3%	87.0%	87.4%	90.0%
Non-Maori	54.0%	65.4%	86.6%	93.0%	93.1%	90.0%

Rationale

Along with cancer, cardiovascular (heart and circulatory) disease is the most common long term condition.

Prevalence of CVD increases with age, so action now is imperative in the face of the ageing population.

Regular screening identifies those at risk of developing cardiovascular disease, for whom lifestyle and clinical interventions can prevent or delay its onset. Regular screening also helps earlier identification of those who already have the condition, and this promotes more healthy outcomes for them.

Screening for cardiovascular disease is one of the six national Health Targets.

Outputs

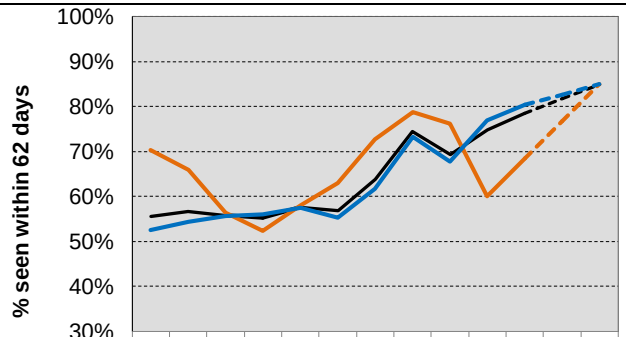
50,932 CVD risk assessments performed in primary care over the five years to Mar 2016. (The total number screened over five years is a more sensible indicator of coverage than the most recent annual figure, because different numbers of people have been screened during each of the five years.)

3.4 Output Class: Intensive Assessment and Treatment

Note: This section used to have a measure concerning unplanned readmissions which used OS8 from the quarterly reports, but OS8 has been held in abeyance since 2015/16 Q1 while the Ministry has reconsidered how it should be calculated. Since the old measure is to be changed, there is no benefit from including 2015/16 data in the SPE. The Ministry plans to introduce the new measure in 2016/17 Q1, so an unplanned readmissions measure will be reinstated in next year's SPE.

Impact: If curable, increased likelihood of survival; if incurable, reduced severity of symptoms

Measure: % of patients who receive their first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks



	2013/14 Q1	Q2	Q3	Q4	2014/15 Q1	Q2	Q3	Q4	2015/16 Q1	Q2	Q3	Q4	2016/17 target
Total	55.5	56.6	55.8	55.2	57.6	56.9	63.9	74.4	69.2	74.8	78.6	81.7	85.0
Maori	70.4	65.9	56.4	52.4	58.1	62.9	72.7	78.8	76.2	60.0	68.4	76.7	85.0
Non-Maori	52.6	54.4	55.6	56.0	57.4	55.2	61.7	73.3	67.7	76.9	80.4	82.6	85.0

Measure type:
Coverage

Rationale

Along with cardiovascular disease, cancer is the most common long term condition.

For cancer, some of the biggest gains are to be made by ensuring early access to treatment to improve the chances of recovery or to alleviate symptoms.

Data is supplied by quarter because this data has not been captured for long enough to make it worth presenting annualised data.

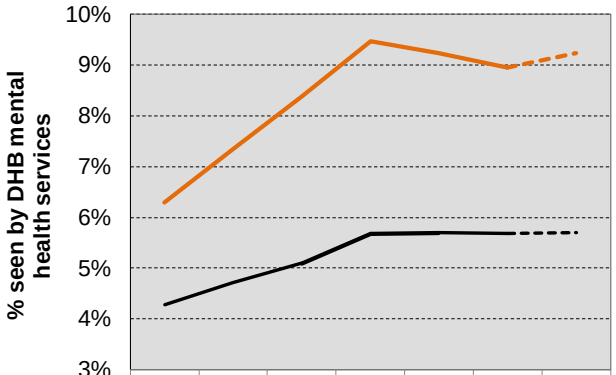
Outputs

284 patients referred urgently with high suspicion of cancer for the twelve months ending March 2016 who commenced first treatment.

Impact: Improved quality of life for both clients and their families; acute episodes are minimised, clients achieve greater stability in their condition

Measure: % of people with enduring mental illness aged 20-64 who are seen over a year

Measure type: Coverage



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 target
Total	4.28%	4.71%	5.09%	5.68%	5.70%	5.68%	5.70%
Maori	6.29%	7.34%	8.38%	9.47%	9.24%	8.96%	9.24%

Rationale

Mental health has been a priority for the health sector since the Mental Health Blueprint was published in 1998; it has since been overtaken by *Rising to the Challenge*, the national mental health and addictions strategy 2012-2017.

Severe disorders permanently affect 3% of the population.

Mild to moderate disorders affect 20% of the population at any one time and 90% over a lifetime.

Outputs

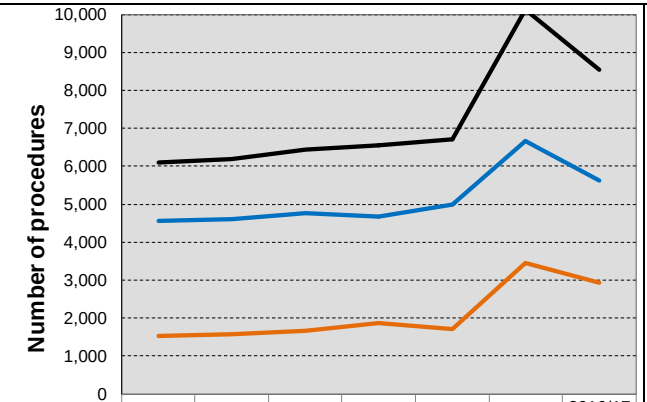
Number of contacts by community mental health services with people who have enduring mental illness (2014/15 extrapolated from 9 months data):

Direct (with client and/or whanau)	95,000
Care coordination (on behalf of client, with another agency)	18,000

Impact: Fewer debilitating conditions and delayed onset of long term conditions

Measure:
Increase in elective service discharges

Measure type:
Coverage



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17 target
Total	6,098	6,198	6,434	6,564	6,704	10,123	8,550
Maori	1,537	1,580	1,660	1,877	1,702	3,462	2,924
Non-Maori	4,561	4,618	4,774	4,677	5,002	6,661	5,626

Rationale

Elective surgery is an effective way of increasing people's functioning because it remedies or improves disabling conditions.

Increasing delivery will improve access and reducing waiting times as well as increase public confidence that the health system will meet their needs.

Timely access to elective services is considered by the Ministry of Health to be a measure of the effectiveness of the health system.

One of the six national Health Targets.

Outputs

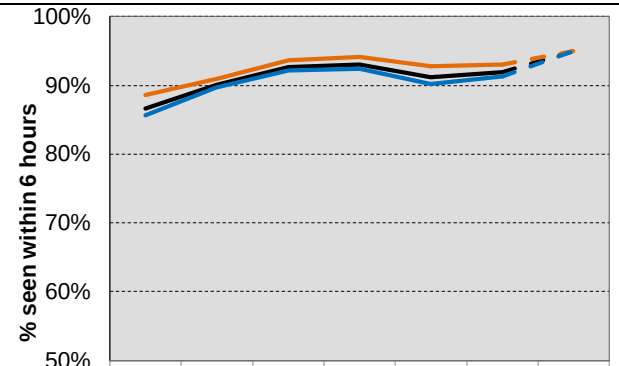
8,575 elective surgical discharges target for 2016/17.

The data used here represents the targets set in each year's Annual Plan. These numbers do not represent total extra elective surgical discharges because every year MoH provides more funding for more procedures, and the amounts cannot be predicted. The most rational way of assessing NDHB's performance is against the targets agreed before the year starts.

Impact: More timely assessment, referral and treatment

Measure:
Patients with an emergency department length of stay of less than 6 hours

Measure type:
Timeliness



	2010/ 11	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/16 to Q3	2016/ 17 target
Total	86.6%	90.1%	92.7%	93.1%	91.2%	92.0%	95.0%
Maori	88.6%	90.9%	93.6%	94.2%	92.8%	93.0%	95.0%
Non-Maori	85.6%	89.7%	92.2%	92.4%	90.2%	91.3%	95.0%

Rationale

The purpose of emergency departments (EDs) is to provide urgent care, so by definition timeliness is important. Long times spent in waiting and receiving treatment in EDs are linked to overcrowding of the ED, compromised standards of privacy and dignity for patients, and poorer clinical outcomes (such as increased mortality and longer lengths of stay for people who are transferred into hospital as inpatients). Reducing ED length of stay will improve the public's confidence in being able to access services when they need to, increasing their level of trust in health services, as well as improving the outcomes from those services. It also ensures resources are used effectively and efficiently.

One of the six national Health Targets.

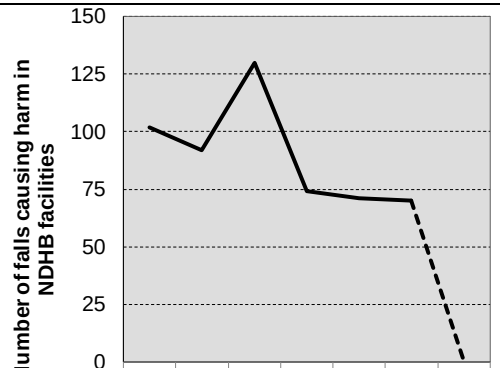
Outputs

Emergency services provided by EDs at Whangarei Hospital, NDHB's most specialised ED, as well as satellite services at the other three hospitals in Kaitaia, Kawakawa and Dargaville.

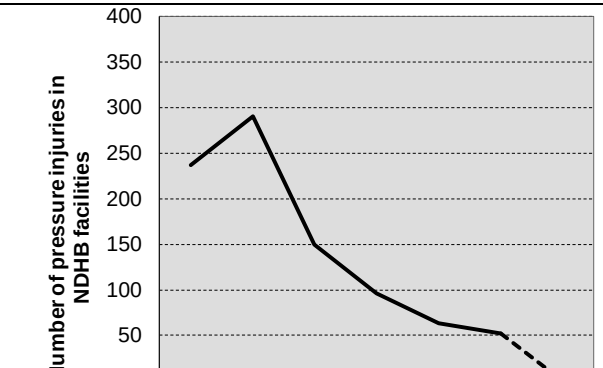
Emergency department attendances for the twelve months ending Mar 2016: 40,087.

Impact: Fewer adverse clinical events.

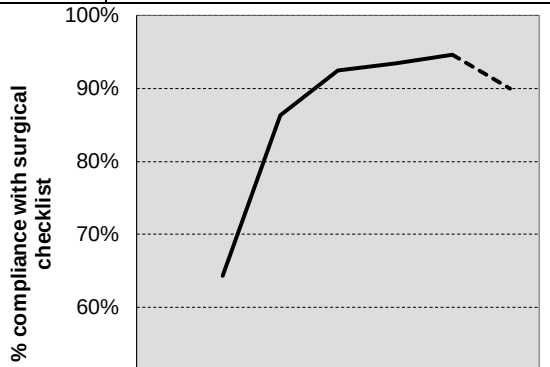
Measures type: Quality



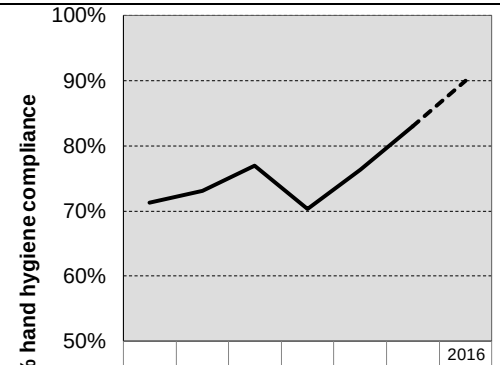
	2010/11	2011/12	2012/13	2013/14	2014/15 to Apr	2015/16 to Q3	2016/17 target
Harm from falls in hospital	102	92	130	74	71	70	0



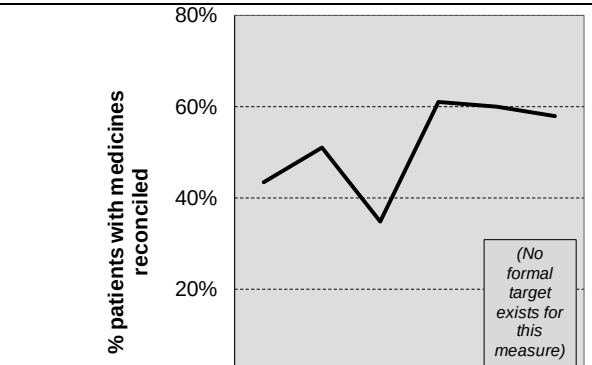
	2010/11	2011/12	2012/13	2013/14	2014/15 to Apr	2015/16 to Q3	2016/17 target
Pressure injuries	237	291	150	96	63	52	0



	2010/11	2011/12	2012/13	2013/14	2014/15 to Apr	2015/16 to Q3	2016/17 target
Checklist compliance		64.3%	86.3%	92.5%	93.5%	94.6%	90.0%



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16 to Q3	2016/17 target
Hand hygiene compliance	71.3%	73.1%	77.0%	70.3%	76.4%	83.0%	90.0%



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16 to Q3
Reconciliations completed	43.4%	51.1%	34.8%	61%	60%	58.0%

Rationale

A significant number of adverse and largely preventable events occur in health services. Quality in health care has become increasingly important over the past few years, and the health environment has demanded more from its quality information and reporting.

These measures comprise NDHB's Quality Accounts, a requirement from the national Health Quality and Safety Commission. Quality Accounts will require annual reports from health and disability service providers regarding the quality of service provided according to specific measures. The initial focus is on NDHB"s hospital services.

Outputs

Advice and monitoring provided by the Quality and Improvement Directorate, which is overseen by the Chief Medical Advisor.

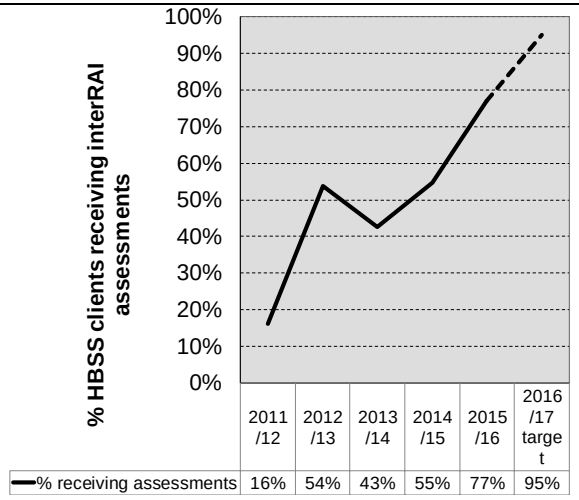
A note about medicine reconciliation: from Jan 2015 HQSC has been measuring this for priority patients only. The data presented here is for *all* patients to make it consistent with older data and provide historical context.

3.5 Output Class: Rehabilitation and Support

Impact: Older people requiring support or care receive services appropriate to their needs.

Measure: % Home and Community Support Services (HCSS) clients assessed using interRai tool

Measure type: Coverage



Rationale

Older people who remain in the community with the assistance of home and community support services are more able to 'age in place' (that is, their lifestyle and supports are more appropriate to their needs). The more older people living safely and independently in the community, the less pressure there is on hospital and aged residential care resources. Good quality clinical assessment for older people who live at home contributes to achieving these aims.

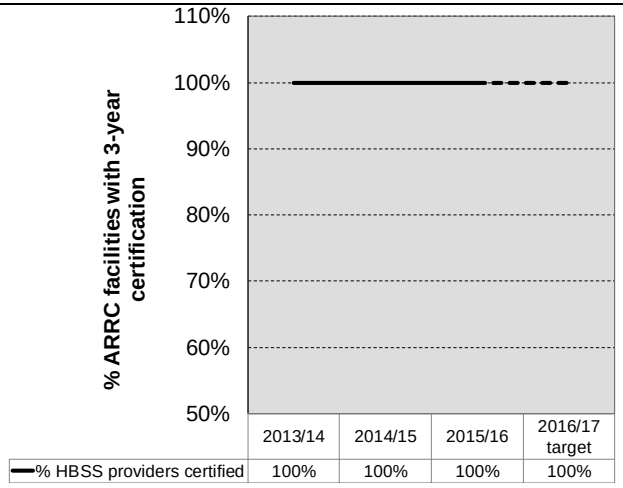
interRAI is collaborative network of researchers in over 30 countries who promote evidence-based clinical practice and policy to improve health care for persons who are elderly, frail, or disabled. InterRAI has developed assessment instruments for a range of populations in various areas of health care, including but not limited to home care and long term care facilities.

Outputs

1,687 clients who receive long term home based support services have ever been assessed using the interRAI Home Care or Contact Assessment tool as at Dec 2015.

Measure: % of HCSS providers certified

Measure type: Quality



Rationale

Certification against the Home and Community Support Sector Standard (NZS 8158:2012) is aimed at ensuring people receive good quality support in their homes. The Standard sets out what people receiving home and community support services can expect and the minimum requirements to be attained by organisations.

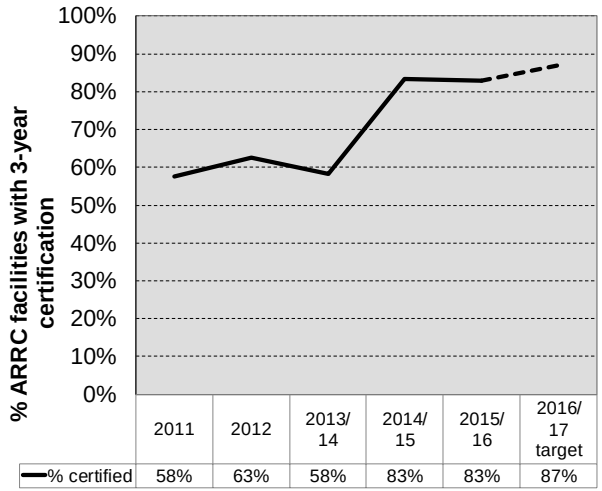
All NDHB home and community support services are certified, and Northland DHB ensures providers maintain their certification status.

Outputs

9 providers of home based support services, providing support to 2,194 people in the community up to Dec 2015.

Measure: % of ARRC providers with at least 3-year certification

Measure type: Quality



Rationale

Certification reduces potential risks to residents by ensuring providers comply with the Health and Disability Services Standards.

The period of certification for aged residential care providers reflects their risk level – the fewer the number and the lower the level of risks identified during audits, the longer the period of certification.

Outputs

DHB aged care contract and MoH certification audit processes have been conducted through a single audit since August 2010. DHBs concentrate on working with providers on corrective action plans to address any matters identified though the audits, monitoring progress against the agreed corrective action plans, and managing risks that may arise. The measure does not include certification for any new providers because that automatically reverts to a single year and is therefore not necessarily related to quality of service.

The figure for 2015/16 comprises 18 facilities with 3-year certification and 2 with 4-year, out of a total of 23 facilities (20/23 =87%).

Statement of Financial Performance - By Output Class

	Intensive Assessment & Treatment	Early Detection & Management	Prevention	Rehabilitation & Support Services	
DHB Provider Revenue	263,267,448	27,799,140	1,978,361	12,004,480	305,049,429
Other Provider Revenue	8,533,416	5,525,434	8,941,338	2,976,929	25,977,117
Less Revenue Offsets - Note 1	- 3,058,750	- 1,719,625	- 2,822,723	- 983,380	- 8,584,477
DHB Funder Revenue	81,712,320	109,684,942	9,592,404	64,957,469	265,947,134
DHB Governance & Administration	4,604,849	-	-	-	4,604,849
Total SOI Revenue	355,059,283	141,289,890	17,689,380	78,955,498	592,994,052
Personnel Costs					
Medical Labour	56,742,032	2,996,152	1,419,578	43,080	61,200,842
Nursing Labour	71,492,935	7,581,289	612,397	4,652,370	84,338,990
Allied Health Labour	23,625,277	8,672,054	2,943,192	3,043,168	38,283,691
Non Clinical Support Labour	4,652,194	203,337	63,815	80,159	4,999,505
Management and Admin Labour	27,680,386	4,163,453	1,789,566	1,532,555	35,165,961
Non-Personnel Operating Costs					
Outsourced Clinical Services	5,559,160	1,201,545	30,842	137,236	6,928,783
Oth Clinical Supp	30,323,383	2,224,297	684,636	1,880,724	35,113,040
Implants	4,977,950	-	-	-	4,977,950
Pharmaceuticals	6,375,301	81,946	4,198	279,701	6,741,145
Infrastructure and Non Clinical	28,509,129	4,183,089	1,116,909	1,860,798	35,669,925
Allocated Pharmaceuticals	-	-	-	-	-
Cost of Capital	9,034,811	1,024,058	304,475	451,027	10,814,371
CTA Recoveries	- 3,572,645	- 175,397	- 39,935	- 61,184	- 3,849,160
Patient Support	4,585,139	10,427	10,098	12,687	4,618,352
Sterile Supplies	250,985	4,369	1,255	3,593	260,202
Provider Payments - to providers					
Personal Health	68,604,064	106,836,510	4,538,891	1,903,084	181,882,549
Mental Health	13,380,171	2,763,232	-	-	16,143,403
Disability Support Services	111,921	-	-	61,945,487	62,057,408
Public Health	-	-	-	-	-
Maori Health	-	520,148	5,061,920	65,028	5,647,095
Total SOI Operating Expenditure	352,332,193	142,290,508	18,541,836	77,829,514	590,994,052
Surplus (Deficit)	2,727,090	- 1,000,618	- 852,456	1,125,984	2,000,000

Note One. Revenue Offsets for Costing Standards

4 Financial Performance

NRHP 2 Northern Region Context \ Drivers for change \ Financial sustainability

4.1 Introduction

The government's fiscal priorities include returning to a surplus position in 2016/17. The funding to the DHB reflects this and a small surplus of $2M has been planned for 2016/17.

Northland DHB has consistently maintained a balanced budget. This has met the requirements of the Minister and has allowed the DHB some flexibility in allocating resources to new needs and services. In the climate of financial constraints and capped funding in real terms, maintaining a balanced budget remains an important goal of Northland DHB. This goal is becoming increasingly challenging, with year-on-year growth in demand – especially in acute clinical services, mental health and health of older people – meaning that we will need to focus on productivity improvements and cost efficiencies across all our services if we are to meet the goal of a balanced budget without service reductions.

For 2016/17 additional risks have emerged which include additional costs to administer the newly funded cancer drugs, demand exceeding funding for these new drug treatments, costs of industrial action, and additional costs to meet ESPI compliance in the face of industrial action. The Ministry of Health has acknowledged that Northland does carry risk over and above that documented within this plan and that there is a high probability that some of the risks will compromise our ability to meet the full $2M surplus.

Northland DHB continues to seek productivity improvements and cost efficiencies in the way we operate. At a local level, cost saving and productivity improvement targets are embedded in each division. Regionally, we work with Waitemata DHB, Auckland DHB and Counties Manukau DHB through the Health Alliance (hA) and Northern Region Alliance (NRA) to maximise cost savings through regional shared services in finance, supply chain, procurement and information technology, while working to ensure regional consistency on funding decisions such as NGOs, community laboratory etc.

At a national level, Northland DHB has committed to national procurement initiatives led by NZ Health Partnerships, such as Finance, Procurement and Supply Chain (FPSC), Shared Banking and Insurance, National Procurement and National Infrastructure Platform.

Northland DHB will also continue to work with PHARMAC to determine the impact this will have on budgets once PHARMAC has completed analysis on the data. This will involve the following activity:

Hospital medical devices interim procurement	Support PHARMAC in continuing this role. Any net budget-impact savings to DHBs from this activity are yet to be determined.
Hospital medical devices category management establishment	Expected to have no impact on 2016/17 planning.
Hospital pharmaceuticals management	Support PHARMAC in progressing this role. Cost curve on hospital medicines costs should be starting to bend as new technologies are not able to be adopted without PHARMAC-identified savings. Note: no data is available on growth within existing medicines usage, so local cost forecasting will need to continue.
Hospital pharmaceuticals budget management	Expected to have no impact on 2016/17 planning.

The Northland Health Services Plan is currently being implemented, and $5.0 million has been set aside in the Strategic Investment Fund to fund initiatives to reduce acute demand on hospital services and deliver more care in the community setting over the next 3 years

4.2 Four-year Forecast

Northland DHB will break even in 2016/17 as per the Government's fiscal policy and a break-even performance for each of the following 2 years detailed in the financial template. Budgeting for revenue has been a "top down" approach and matches the 2015/16 funding envelope and other revenue estimates. Expenditure has been budgeted from the "bottom up" by each division as a business-as-usual approach. Known strategic initiatives, such as Neighbourhood Health Homes, have been budgeted as specific projects.

For 2016/17, health of older people volumes are projected to continue to grow at 6% ($2.8 million) and we have budgeted to recognise inflationary pressure with a price increase equivalent to CCP for all our community providers.

Within DHB-owned services, productivity improvement and/or cost savings targets of $5.0 million have been set to counterbalance the increased depreciation, salary cost creep, and reduced interest income due to our investment in strategic building development and information technology in recent years. Cost savings targets of $(TBA) million have been set for the HBL-led National Procurement and Price Harmonisation programmes.

4.3 Productivity Initiatives

Our major productivity initiatives are detailed in 2.14 Living within our means.

Full time equivalent (FTE) staff management.

Careful management on FTE numbers continues to be a focus. There have been increases in FTE as a result of in-sourcing renal patient transport services, and new funded services in mental health. Management and administrative FTEs have been held, despite increases in activity and new services. FTE levels remain under the FTE cap.

4.4 Capital Plan

Strategic projects approved in 2013/14 and scheduled for completion in 2014/15 and 2015/16 include site-wide infrastructure and ancillary works at Whangarei Hospital to enable the building of the new maternity unit, the Jim Carney Cancer Treatment Centre, gymnasium and carparking. Implementation of our new patient management system is underway and is now scheduled for completion in early 2016/17. These strategic initiatives have been funded from existing cash resources and crown debt.

Baseline capital asset replacement for 2016/17 has been budgeted at $6.9 million. We have budgeted to replace the hospital wide patient monitoring systems in 16/17.

Strategic projects currently not yet approved include Integrated Family Health Centres, Bay of Islands Hospital refurbishment, new Whangarei ED/AAU block, Whangarei Hospital kitchen relocation, clinical training centre, multi-level carpark and refurbishing Whangarei Hospital wards. Of these projects NDHB will be seeking crown debt financing for the ED / AAU block, kitchen relocation, clinical training centre, refurbishing Whangarei Hospital wards and multi-level carpark. This has been reflected in the 2016/17 and future years' Financial Position and Cash Flow.

The single stage business case for the Bay of Islands project will be completed by May 2016 with construction being completed in 2016/17. The strategic assessment business case for the wider ED/AAU and kitchen block will be completed in mid 2016. The indicative business case for this project will then be developed for mid 2016 with the aim of construction commencing by 2017.

4.5 Assets

Assets behave been revalued at 30 June 2015.

4.6 Disposal of Land

If Northland DHB decides to dispose of any land transferred to or vested in the DHB, we will do so under the New Zealand Public Health and Disability Act 2000. Northland DHB has no plans at this time to dispose of any land.

4.7 Financial Statements

Statement of Comprehensive Income

$000s

	2014-15 Audited Actuals	2015-16 Forecast	2016-17 Budget	2017-18 Budget	2018-19 Budget	2019-20 Budget
DHB Provider Revenue	305,915	313,008	331,027	344,268	357,522	370,750
DHB Funder Revenue	237,911	247,582	256,167	266,414	276,671	286,908
DHB Governance & Administration	3,346	3,932	4,822	5,015	5,208	5,400
Inter District Flow Revenue	8,923	7,861	9,563	9,946	10,328	10,711
Total Revenue	556,094	572,383	601,579	625,642	649,729	673,769
DHB Provider Operating Expenditure	285,127	294,090	305,070	317,813	331,072	344,308
DHB Non Provider Funded Services	178,174	178,699	190,794	198,425	206,065	213,689
DHB Governance & Administration	3,864	3,689	4,822	5,015	5,208	5,400
Inter District Flow Expense	67,360	72,981	74,936	77,934	80,934	83,929
Total Operating Expenditure	534,525	549,459	575,622	599,187	623,279	647,327
Earnings before Interest, Depreciation, Abnormals & Capital Charge	21,569	22,924	25,956	26,454	26,449	26,442
Less						
Interest on Term Debt	1,070	994	889	861	830	798
Depreciation	11,188	12,061	13,143	13,669	14,195	14,721
Revaluation	-	-	-	-	-	-
Earnings before Abnormals & Capital Charge	9,311	9,869	11,924	11,924	11,424	10,924
Profit/(Loss) on Sale of Assets	-	-	-	-	-	-
Net Operating Surplus (Deficit)	9,311	9,869	11,924	11,924	11,424	10,924
Capital Charge	8,899	9,932	9,924	9,924	9,924	9,924
Surplus (Deficit)	**412**	**(63)**	**2,000**	**2,000**	1,500	1,000
Revaluation of Fixed Assets	(14,296)	0	0	0	0	0
(Gains)/Losses in Asset for Sale Financial Assets Reserve	169	114	-	-	-	-
Comprehensive Income	**14,539**	**(177)**	**2,000**	**2,000**	**1,500**	**1,000**

Statement of Movements in Equity

$000s

	2014-15 Audited Actuals	2015-16 Forecast	2016-17 Budget	2017-18 Budget	2018-19 Budget	2019-20 Budget
Equity at the beginning of the period	112,367	126,896	126,743	128,743	130,743	132,244
Surplus/Deficit for the period	412	(63)	2,000	2,000	1,500	1,000
Total Recognised Revenues and Expenses	112,778	126,833	128,743	130,743	132,244	133,243
Other Movements						
Revaluation of Fixed Assets	14,296	-	-	-	-	-
Other	(178)	(90)	-	-	-	-
Equity introduced (Repaid)	-	-	-	-	-	-
Equity at end of Period	**126,896**	**126,743**	**128,743**	**130,743**	**132,244**	**133,243**

Statement of Financial Position

$000s

	2014-15 Audited Actuals	2015-16 Forecast	2016-17 Budget	2017-18 Budget	2018-19 Budget	2019-20 Budget
Equity						
Crown Equity	40,355	40,355	40,355	40,355	40,355	40,355
Retained Earnings	4,110	4,047	6,047	8,047	9,548	10,548
Subsidiaries & unrestricted trusts	217	210	210	210	210	210
Revaluation Reserve	82,214	82,131	82,131	82,131	82,131	82,131
Capital Injections	-	-	-	-	-	-
Total Equity	126,896	126,743	128,743	130,743	132,244	133,244
Represented by:						
Assets						
Current Assets	32,469	22,189	27,193	17,143	21,886	29,816
Non-Current Assets	207,585	214,148	210,744	222,365	218,660	211,429
Total Assets	240,054	236,337	237,937	239,508	240,546	241,245
Liabilities						
Current Liabilities	71,130	67,561	67,561	67,559	67,482	67,181
Non-Current Liabilities	42,028	42,032	41,633	41,206	40,820	40,820
Total Liabilities	113,158	109,593	109,194	108,765	108,302	108,001
Net Assets	**126,896**	**126,743**	**128,743**	**130,743**	**132,244**	**133,244**

Statement of Cash Flows

$000s

	2014-15 Audited Actuals	2015-16 Forecast	2016-17 Budget	2017-18 Budget	2018-19 Budget	2019-20 Budget
Cash Flows from Operating Activities						
Operating Income	549,193	575,255	600,285	624,296	648,332	672,320
Operating Expenditure	545,539	567,553	585,546	609,114	633,206	657,252
Net Cash from Operating Activities	3,654	7,702	14,739	15,182	15,125	15,069
Cash Flows from Investing Activities						
Interest receipts 3rd Party	3,251	1,467	2,171	1,345	1,397	1,449
Sale of Fixed Assets	12	-	-	-	-	-
Purchase of Fixed Assets	(36,997)	(15,409)	(24,740)	(25,290)	(10,490)	(7,490)
Decrease in Investments and Restricted & Trust Funds Assets	(12,764)	2,418	15,000	-	-	-
Net Cash from Investing Activities	(46,497)	(11,524)	(7,569)	(23,945)	(9,093)	(6,041)
Cash Flows from Financing Activities						
Equity injections (repayments)	-	-	-	-	-	-
Borrowings	1,924	(505)	(399)	(427)	(459)	(299)
Interest Paid	(1,063)	(901)	(889)	(861)	(830)	(798)
Repaid debts	-	-	-	-	-	-
Other Non-Current Liability Movement	(74)	(7)	-	-	-	-
Net Cash from Financing Activities	787	(1,414)	(1,288)	(1,288)	(1,289)	(1,097)
Net Increase/(Decrease) in Cash held	(42,057)	(5,236)	5,882	(10,051)	4,744	7,930
Add opening cash balance	50,922	8,865	3,629	9,511	(539)	4,204
Closing Cash Balance	8,865	3,629	9,511	(539)	4,204	12,134

Note: *Cash balance includes short term investments which are considered cash or cash equivalents*

Key Financial Analysis and Banking Covenants

	2014-15 Audited Actuals	2015-16 Forecast	2016-17 Budget	2017-18 Budget	2018-19 Budget
Financial Analysis					
Term Liabilities and Current Liabilities	113,158	109,593	109,194	108,765	108,302
Debt	26,631	26,234	25,835	25,408	24,949
Owners Funds	126,896	126,743	128,743	130,743	132,244
Total Assets	240,054	236,337	237,937	239,508	240,546
Owners Funds to Total Assets	52.9%	53.6%	54.1%	54.6%	55.0%
Interest Expense	1,070	994	889	861	830
Depreciation Expense	11,188	12,061	13,143	13,669	14,195
Surplus/(Deficit)	395	- 63	2,000	2,000	1,500
Interest Cover	11.82	13.07	18.03	19.20	19.91
Debt/Debt + Equity Ratio	17%	17%	17%	16%	16%
Banking Covenants					
Debt/Debt + Equity Ratio	17.3%	17.1%	16.7%	16.3%	15.9%
Interest Cover	11.8	13.1	18.0	19.2	19.9
Interest Cover Minimum	3.0	3.0	3.0	3.0	3.0

Consolidated Statement of Financial Performance ($000s)	2014-15 Audited Actuals	2015-16 Forecast	2016-17 Budget	2017-18 Budget	2018-19 Budget	2019-20 Budget
MOH Devolved Funding	516,264	536,964	566,038	588,680	611,344	633,964
MOH Non-Devolved Contracts (provider arm side contracts)	14,586	14,740	13,986	14,545	15,105	15,664
Other Government (not MoH or other DHBs)	5,470	5,779	5,581	5,805	6,028	6,251
Patient / Consumer sourced	608	558	579	602	626	649
Total Other Income	9,065	5,315	4,641	4,826	5,012	5,197
InterProvider Revenue (Other DHBs)	1,178	1,168	1,190	1,238	1,285	1,333
IDFs - All Other (excluding Mental Health)	8,923	7,861	9,563	9,946	10,328	10,711
Total Consolidated Revenue	556,094	572,383	601,579	625,642	649,729	673,769
Personnel Costs	197,885	205,521	216,471	225,210	234,457	243,688
Outsourced Services	23,956	23,966	21,805	22,677	23,550	24,422
Clinical Supplies	43,230	44,862	47,314	49,207	51,101	52,992
Infrastructure & Non-Clinical Supplies	23,920	23,351	24,303	25,735	27,172	28,608
Finance Costs	9,969	10,926	10,813	10,785	10,754	10,722
Depreciation	11,188	12,061	13,143	13,669	14,195	14,721
Personal Health	170,032	173,137	179,630	186,815	194,007	201,186
Mental Health	13,315	13,948	14,636	15,221	15,807	16,392
Disability Support Services	55,963	58,308	65,017	67,617	70,220	72,819
Public Health	688	690	745	774	804	834
Maori Health	5,536	5,596	5,704	5,932	6,160	6,388
Total Operating Expenditure	555,683	572,367	599,579	623,642	648,229	672,770
Surplus (Deficit)	**412**	**16**	**2,000**	**2,000**	**1,500**	**999**

Provider Statement of Financial Performance ($000s)	2014-15 Audited Actuals	2015-16 Forecast	2016-17 Budget	2017-18 Budget	2018-19 Budget	2019-20 Budget
MOH Non-Devolved Contracts (provider arm side contracts)	14,586	14,740	13,986	14,545	15,105	15,664
Other Government (not MoH or other DHBs)	5,470	5,779	5,581	5,805	6,028	6,251
Non-Government & Crown Agency Sourced	9,673	5,872	5,220	5,429	5,638	5,846
InterProvider Revenue (Other DHBs)	1,178	1,168	1,190	1,238	1,285	1,333
Internal Revenue (DHB Fund to DHB Provider)	275,008	285,449	305,049	317,251	329,466	341,656
Total Provider Revenue	305,915	313,008	331,027	344,268	357,522	370,750
Personnel Costs	196,698	204,368	215,163	223,850	233,045	242,224
Outsourced Services	23,256	23,189	20,872	21,707	22,543	23,377
Clinical Supplies	43,070	44,551	46,538	48,400	50,263	52,123
Infrastructure & Non-Clinical Supplies	22,103	21,983	22,497	23,857	25,222	26,585
Finance Costs	9,969	10,926	10,813	10,785	10,754	10,722
Depreciation	11,188	12,061	13,143	13,669	14,195	14,721
Total Operating Expenditure	306,285	317,078	329,026	342,267	356,022	369,751
Surplus (Deficit)	**(370)**	**(4,069)**	**2,000**	**2,000**	**1,500**	**1,000**

Governance Statement of Financial Performance ($000s)	2014-15 Audited Actuals	2015-16 Forecast	2016-17 Budget	2017-18 Budget	2018-19 Budget	2019-20 Budget
Government & Crown Agency Sourced	3,346	3,932	4,822	5,015	5,208	5,400
Total Governance Revenue	3,346	3,932	4,822	5,015	5,208	5,400
Personnel Costs	1,186	1,153	1,307	1,359	1,411	1,464
Outsourced Services	700	778	933	970	1,008	1,045
Infrastructure & Non-Clinical Supplies	1,817	1,447.46	1,806	1,878	1,950	2,023
Depreciation	-	-	-	-	-	-
Total Operating Expenditure	3,864	3,689	4,822	5,015	5,208	5,400
Surplus (Deficit)	**(518)**	**243**	**0**	**0**	**0**	**0**

Funder Statement of Financial Performance ($000s)	2014-15 Audited Actuals	2015-16 Forecast	2016-17 Budget	2017-18 Budget	2018-19 Budget	2019-20 Budget
MOH Devolved Funding	516,264	536,964	566,038	588,680	611,344	633,964
Inter District Flows	8,923	7,861	9,563	9,946	10,328	10,711
Total Funder Arm Revenue	525,187	544,825	575,601	598,625	621,673	644,674
Personal Health	397,458	410,488	438,956	456,514	474,090	491,631
Mental Health	53,102	53,454	53,911	56,067	58,226	60,380
Disability Support Services	61,287	64,191	70,540	73,362	76,186	79,005
Public Health	2,155	2,349	1,515	1,576	1,637	1,697
Maori Health	6,540	6,647	5,857	6,091	6,326	6,560
Other	3,346	3,932	4,822	5,015	5,208	5,400
Total Operating Expenditure	523,888	541,062	575,601	598,625	621,673	644,674
Surplus (Deficit)	**1,300**	**3,763**	**0**	**0**	**0**	**0**

5 Stewardship

NRHP 3 Our direction \ N. Region Future Landscape \ Aligning enablers

5.1 Financial Management Systems

NRHP: Enablers\ Procurement and Supply Chain; Enablers\ Facilities & Capital

The National Health Board monitors performance of DHBs. NDHB provides financial reports monthly and non-financial reports (Health Targets and other measures) every quarter.

Once a year, Audit NZ audits our financial statements and our Annual Report; the latter includes our Statement of Performance Expectations from the Statement of Intent. Our regional internal audit service audits and monitors our financial systems and performance, as well as auditing and monitoring our shared service agency healthAlliance to ensure the robustness of their systems.

Northland DHB monitors service-by-service progress on finance and performance at monthly Internal Planning, Performance Monitoring and Reporting (IPPMR) meetings, which are attended by senior managers and their business analysts.

Our financial management systems allow us to set targets and monitor performance on finance, workforce and service delivery through the monthly IPPMR meetings. The results are fed to the Executive Leadership Team and consolidated each month for the board of governance and its associated subcommittees.

NDHB participates in regional and national processes aimed at achieving value-for-money. Auckland-based healthAlliance provides regional oversight of information systems and technology, and has enabled NDHB to implement the Oracle financial system which offers a virtually paperless requisition-to-payment system. NZ Health Partnerships was established nationally to save money by reducing administrative, support and procurement costs.

At least two-thirds of NDHB's operating expenditure is on workforce, and we continually review staffing patterns and practices to reduce costs.

5.2 Information Services

NRHP 5 Enablers \ Information systems

Effective information systems are a fundamental enabler of the Northern Region's whole-of-system approach to health service delivery. The direction on information management, systems and services in the Northern Region is set by the *Northern Regional Information Strategy* (RIS 2010-20).

NDHB recognises that the direction of IT investment is led by strong business and clinical architecture. This year, the governance focus with our regional partners will be on:

- continuing to strengthen our shared information service, with a focus on responsiveness and value
- participating in national initiatives including planning for the National Health Plan and the National Infrastructure Platform
- development of the business case for a regional electronic health record, in parallel with a refresh of the RIS10-20
- continuing investments in electronic support of care models that are closer to the patient.

Northland's stewardship focus this year is on continuing to embed strong district-wide ownership of our IT investment plan and supporting the clinically led initiatives to codesign and integrate care models across the district.

5.3 Clinical Leadership

↪ NRHP 3 Our direction \ N. Region Future Landscape \ Clinical leadership

Involving clinicians in planning and management discussions and decisions is essential to improving services. NDHB's clinicians form an integral part of our management structures and processes and are intimately involved in regional and national planning processes and innovation. During 2014/15 the number of clinicians involved with the Clinical Governance Board was significantly increased. During 2015/16 their involvement with this important oversight group will support the organisation's work to develop strategy aimed to improve quality of care and patient safety.

A Capital Planning Committee has been formed which allows senior clinicians to prioritise bids for capital equipment throughout the organisation. The committee scores detailed bids against a template and this ensures capital is used to fund purchases of equipment which provide the most benefit for our population.

A 12 month intensive leadership course is again being funded by NDHB to provide training for clinicians and managers aspiring to senior positions with the organisation. The training is provided by consultants who have an excellent reputation within the health sector and has been well received by participants.

A clinical governance group spanning primary and secondary care has been introduced by NDHB to improve systems and quality of care at the interface between hospital and community services. This is seen as a particularly important initiative because improving transfer of care between these areas has historically proven difficult. Collaborative working within this group has already successfully addressed some longstanding issues.

5.4 Quality, Safety and Risk Management

↪ NRHP 2 Northern Region Context \ Drivers for change \ Quality and patient safety
3 Our direction \ N. Region Future Landscape \ Patient participation and engagement in health improvement

Northland DHB plays an active part in developing and implementing the region's 'First Do No Harm' quality improvement programme. This programme serves as a conduit for work coming through at national level from HQSC and also supports projects developed at regional level.

NDHB staff regularly attend quality and safety courses and seminars at Counties Manukau DHB's Ko Awatea facility. Quality and safety are integral to the way Northland DHB works. Our emphasis on quality and safety aligns with the aims of the Health Quality and Safety Commission and with the Regional Health Plan's First Do No Harm priority.

Quality and safety includes monitoring clinical risk, adverse events and errors, complaints, benchmarking with other DHBs, improvements to clinical systems and undertaking clinical audit. An electronic risk register allows all parts of the organisation to record and manage risk. The most serious risks are reviewed monthly with senior clinical staff to ensure they are mitigated to acceptable levels. A Reportable Events Committee meets fortnightly to review significant incidents. These are investigated and lessons learned are disseminated appropriately and where appropriate transferred to the Risk Register for ongoing monitoring. Datix software has recently been introduced to Northland DHB to support the robust management of incidents in this way.

NDHB has an annually reviewed Quality and Safety Plan which lays out the programme, principles, processes, structures, roles and relationships that underpin quality and safety. During 2014 an external review of quality within the organisation provided a roadmap for quality improvement which will extend into 2015/16 and 2016/17. Six-weekly quality reports are produced for the Board's Hospital Advisory Committee, the Patient Safety Committee and the Clinical Governance Board. These reports include performance against national targets such as hand hygiene, our local and national patient experience survey results, review of serious and sentinel events which have occurred, as well as performance against our local targets for falls, decubitus ulcers and VTE prophylaxis.

A newly appointed clinical audit lead has developed a robust framework for clinical audit across the organisation and this will be supported by a Clinical Audit Committee.

The quality improvement framework adopted by Northland DHB should support the provision of high quality, person-centred, safe and evidence-based care to our community. The Quality Directorate will support the organisation to ensure that individual encounters are consistently person-centred, clinically

effective and safe by establishing a shared understanding of quality and safety and a commitment to place this at the heart of everything we do. The framework aligns to the relevant headline targets of the Northland Health Services Plan and will incorporate major national and regional projects that are being championed by the Health Quality & Safety Commission (HQSC) and First Do No Harm (FDNH).

This Patient Safety and Quality Improvement framework is a formal, documented set of quality commitments to our patients/ clients/ staff and community to improve quality through focused targets and actions. Aligned with our system and national priorities, with this we can then begin to understand what progress the organisation is making in achieving targets on priority improvement areas. Additionally, it provides rich information for the system to better understand how we can collectively spearhead improvement efforts.

Quality improvement objectives should be standardised across the organisation. In addition to being owned by the organisation, the framework is developed under the umbrella of a common national vision and provides a system-wide platform for quality improvement. This vision is expressed through the priority indicators that are included in the framework. These quality themes reflect New Zealand's vision for a high-performing health care system.

The goal is to establish priorities that align organisationally, regionally and nationally, to familiarise ourselves with performance data in our organisation, and understand how we can use this to drive measurable improvement and build capacity within. Other patient safety system priorities will be incorporated as needed into the development of the framework for optimal alignment across the region.

5.5 Performance and Management of Assets

NRHP 5 Enablers\ Facilities & Capital

Northland DHB is entering into a major investment cycle as it redevelops its facilities at Bay of Islands and Whangarei Hospitals. NDHB has been classified as a Tier 2 Intensive Investment Agency under the recently introduced Investment Management and Asset Performance (IMAP) system. From this system Cabinet will approve an Investor Confidence Rating for NDHB that reflects our ability to manage our asset portfolio and to successfully deliver promised benefits.

NDHB has redeployed staff to focus on fixed assets. This corporate role is leading the development of a Long Term Investment Plan (LTIP) that sets out for the next ten years the capital planning and asset management functions that will enable NDHB to continue meeting health service provision requirements for the organisation well into the future. The role will assist by performing the following functions:

- working with the other Northern Regional DHBs to support the improvement of investment management systems
- actively supporting the NDHB capital expenditure function, including capital planning and budgeting, approval, management, implementation, monitoring and reporting
- maintaining and updating NDHB's capital- and asset-related policies, procedures manuals and forms
- assisting services with the development and reviewing of capital proposals and business cases
- demonstrating to Treasury the success of projects including delivery of benefits, scope, timeframes and cost
- assessing and reporting asset performance including utilisation, condition and fitness for purpose against an expected level
- providing business analysis and financial management support to corporate and other services as required from time to time.

NDHB has a number of construction projects underway or recently completed.

New Maternity Unit, Whangarei Hospital	Construction of this facility on Hospital Road on the site of the former Wards 6-9 was completed on 23 February 2016. It comprises 5 birthing rooms, 2 assessment rooms, 4 clinic rooms and 18 antenatal beds. To avoid future disruptions the second level is being constructed to be held as a shell until the configuration of the overall site is finalised.
Office Building, Whangarei Hospital	A new office building has been built on the Whangarei Hospital campus. This has allowed staff located in a number of leased properties to be colocated at the hospital, saving $200k annually in building lease costs.
Integrated Family	NDHB, Ngati Hine Health Trust and local GPs are working together on

Healthcare Centre, BOI Hospital	the development of an IFHC at BOI Hospital.
Integrated Family Healthcare Centre, Dargaville Hospital	NDHB and the Dargaville Medical Centre are working together on the proposed redevelopment of Dargaville Hospital.

Timeframe for ED / AAU:

Strategic Assessment	August 2016
Indicative Business Case	December 2016
Detailed Business Case	May 2017

Indicative costs for our major projects:

Year	All capital ($000)	Major
2016/17	24,740	10,200
2017/18	35,490	13,000
2018/19	23,490	13,000

Of these amounts, the cost of the ED / AAU block is about $47M (which includes the shell for the theatres).

5.6 Primary and Community Providers

↳ NRHP 6 Governance and leadership \ Whole of system implementation

All of NDHB's services link in some way to Northland's primary and community providers, including general practices and PHOs, pharmacies, the community laboratory, Maori health providers, mental health providers and aged-care providers. NDHB has agreements with over a hundred primary and community providers in Northland. These are negotiated through our Portfolio Managers who also monitor provider performance in relation to service specifications (most of which are determined nationally) and use this information to assist with planning.

Primary and community organisations are involved in various NDHB governance and planning groups. The two Northland PHOs' Chief Executives are members of NDHB's Executive Leadership Team (ELT). He Mangai Hauora mo te Waka a Taonui, which oversees Maori health at a governance level, has representation from three iwi. The Alliance Leadership Team (Te Roopu Kai Hapai Oranga) comprises representatives from Northland DHB, Te Tai Tokerau and Manaia Health PHOs, Hokianga Health Enterprise Trust, Maori Providers and NGOs. The Northland Health Services Plan Oversight Group comprises ELT plus representatives from three Maori providers.

The Northland Community Pharmacy Service Development Group includes representation from the DHB, PHOs, community pharmacy and hospital pharmacy. This group supports and enables open communication between pharmacies and the DHB on issues relating to the delivery of community pharmacy services within Northland. The role of the group is to encourage the development and delivery of primary care services that can be delivered in a sustainable way by pharmacists and/or their teams to improve health outcomes of Northlanders. Funding has been allocated to this group to enable this.

In addition, a Northland representative attends the metro Auckland Pharmacy Advisory Group, a similar joint DHB/ pharmacist advisory group, to ensure ideas, issues and solutions are shared across the Northern Region.

Northland pre-school and school-based dental services are provided by a combination of DHB and community dental providers. Representatives from all three providers, plus DHB funding and planning, meet regularly to ensure provider input into all strategic planning. Northland's Rural Service Level Alliance Team (Rural SLAT) provides governance and direction to support sustainable rural practice. Its membership comprises representation from general practice, nursing, PHOs, pharmacy and the DHB. It holds responsibility and oversight over a devolved budget which includes provision for safe out of hours

services, rural workforce development, and other areas which require a rural lens. The Rural SLAT makes recommendations to NDHB to ensure rural needs are met in Northland.

5.7 Building Capability

↪ NRHP 5 Enablers (Information systems, Workforce, Facilities and capital)

Building the capability within Northland DHB to enable us to run the organisation more effectively is addressed throughout the Annual Plan.

2.3.2 NHSP Neighbourhood Healthcare Homes (NHH): support general practices/ networks to develop systems and processes to become more effective and patient-centric by streamlining operations, changing the way patients and clinicians interact, and improving patients' journey through the health system by moving from reactive to proactive health care.

2.3.4 Telehealth: a natural byproduct of telehealth is upskilling and workforce enablement, which also improves patient safety.

2.3.6 Care Connect: the beginning of an electronic health record, enabling clinical partnerships that span across the health continuum and ensure the right information is available at the right time to the right provider.

2.3.7 Community pharmacy: develop and promote pharmacists to work to the top of their scope, offering additional services to patients that add value to health outcomes.

2.5 Mental Health and Addictions Services (MHAS):

- establish project management capacity to allow strategic service development work to be completed and enhance the performance and sustainability of MHAS
- establish a MHA services workforce development plan aligned with the five year strategic plan and vision
- implement interventions that will upskill mental health and addiction nurses in physical health assessment, building on the successful pilot completed in the Far North in 2015
- establish secure reporting database (including RBA and PRIMHD) reporting to allow across-sector data analysis for strategic and operational planning.

2.9 Whanau Ora:

- engage with appropriate agencies to identify opportunities to support Whanau Ora providers and collectives in Te Tai Tokerau by strengthening Maori workforce capability and capacity, including Maori in health planning and using supporting data on needs and service utilisation in service delivery and design.
- utilise the 'Health Equity Assessment Tool' and 'Equity of Health Care for Maori: a Framework' as training tools to socialise the importance of eliminating inequities in Te Tai Tokerau and improve primary care to work more effectively with Maori whanau.

2.12 Diagnostic waiting times: support NDHB involvement in a regional nurse endoscopist training programme.

2.15 Information technology: all 9 actions improve the quality, robustness and coverage of information systems.

5.3 Clinical Leadership: training in leadership; clinical governance group to improve systems and quality of care at the interface between hospital and community services

2.13 Quality and safety: new Datix integrated patient safety reporting system and related ongoing education

5.4 Quality, Safety and Risk Management: training for staff

5.8.2 Strengthening our workforce:

- participation in the Workforce Intelligence and Planning Framework
- Workforce Enablement Group with PHOs to prioritise and move forward workforce initiatives
- a wide range of training courses
- e-learning packages.

5.8 Workforce

↪ NRHP 5 Enablers \ Workforce

5.8.1 Managing our Workforce within fiscal restraints

To meet the Government Expectations for Pay and Employment Conditions in the State Sector, Northland DHB has addressed the following:

Recent settlements for both national and DHB-specific Collective Agreements have been successfully achieved within government parameters and Northland DHB's budget plan with the aims of:

- delivering organisational and sector performance improvement
- fostering continuous improvement and productivity enhancement
- supporting effective employee engagement.

Identified business imperatives (such as improved performance and demonstrable recruitment and retention difficulties) have been considered to ensure:

- improved performance through meeting organisational financial and clinical guidelines and expectations for Northland DHB
- specific attention to those areas where there are difficulties in recruitment and retention
- an overall stable workforce with a relatively low turnover rate.

Pay structures and other conditions for employees necessary to support Northland DHB's business and workforce objectives continue to be the subject of ongoing review; these include:

- alignment of rates and conditions across occupational groups where this is appropriate
- application of merit pay steps to enable employees' contributions to be recognised consistently across the organisation while ensuring criteria for merit progression are robust and aligned to service development.

5.8.2 Strengthening our workforce

With support of our PHO partners Northland DHB has established a workforce development roadmap setting out strategic activity to build workforce capability, employee engagement and future-proof service delivery. Key areas of focus in 2016/2017 include:

Embedding of our Values and our Patient & Whanau Centred Care philosophies into our recruitment, learning & development and performance appraisal processes.

Workforce risk management and service specific mitigation plans.

Collaboration with education providers and external groups to grow entry pipelines and support the growth of Maori in under-represented areas.

Delivery of our Learning Pathways curriculum, extending our training and career development offering including additional e-learning packages available to Northland DHB's partners; Manaia and Te Tai Tokerau PHOs, NorthTec and North Haven Hospice.

New leadership and management development framework, courses and initiatives, supporting a management career pathway.

New talent management processes to identify, retain and develop high potentials and succession planning processes to future-proof critical roles.

Initiatives to nurture employee engagement through collaboration, teamwork, and recognition.

Enhanced workforce data management and reporting.

Northland DHB will continue to collaborate on the development of national and regional initiatives including a national Workforce Intelligence and Planning Framework and the Northern Region Management Development Framework and Graduate Management Training Scheme.

A well-resourced staff library further supports learning and development for all staff.

Northland DHB is working with regional partners to ensure that RMOs have access to a wide range of careers advice. This includes active participation in the regional Careers Fair held annually in Auckland and the opportunity for 'one-to-one' meetings with clinical leaders from all specialties.

5.8.3 Safe and Competent Workforce

The Vulnerable Children's Act 2014 which attained royal assent in June 2014 and stresses the Government's commitment to a safe and competent children's workforce. All new Northland DHB staff are safety-checked prior to commencing employment including verification of identity, interview assessment, Police vetting clearance and reference checking. Northland DHB will consult with staff and unions regarding the implementation of safety checks for existing staff in children's worker roles which must be in place by July 2018.

The current recruitment policy and procedures have been updated to reflect the requirements of the act. NDHB meets all the act's requirements regarding child abuse and neglect policies and reporting systems.

The Health & Safety at Work Act 2015, was enacted in September 2015, and requires Northland DHB to maintain an effective Safety Management System to eliminate risk of workplace harm to employees, visitors and contractors, so far as reasonably practicable.

Northland DHB's Safety Management System has maintained the highest accreditation standard in ACC's Partnership Programme audit for over 12 years.

To meet the new duty-of-care obligations outlined in the Health & Safety at Work Act 2015, Northland DHB is introducing new contractor H&S management protocols, additional forums and committees to encourage greater employee participation and is undertaking a review of all significant hazards, continuing to assess the effectiveness of controls and to identify where risk can be eliminated further.

5.8.4 Organisational Health

To achieve organisational goals, and specifically the Northland DHB Health Plan 2013-2017, Northland DHB has sought to improve performance across the organisation and recognised the need to continue supporting employee wellbeing, as an integral element in overall improved organisational performance.

Northland DHB's Equal Opportunities Policy commits to having a workplace where everyone is able to participate and compete equitably, develop to their full potential and be rewarded fairly for their contribution regardless of gender, ethnicity, disability, sexual orientation, age or family circumstances. Management and staff are accountable to perform and behave according the organisation's Values and Code of Conduct, including those related to fairness and non-discriminatory behaviour. In particular the organisation has a zero tolerance to workplace violence, bullying and harassment.

Northland DHB monitors organisation health via a staff satisfaction survey which will be undertaken again in 2016. On each previous occasion the survey has been undertaken, the Chief Executive has required specific and measurable action in response to the top 3 concerns arising from the survey.

A culture of leadership and accountability is advocated. Health and safety, recruitment, selection and induction processes, flexible hours and work design are core to organisation health goals in line with our Equal Opportunities Policy. A culture of learning has been adopted and is reflected in some detail in earlier paragraphs above.

The Northland DHB Occupational Health & Safety Department continues to offer support to managers and staff on health related matters in the workplace, including the use of our occupational health physicians and occupational physiotherapist as required.

All staff have free access to the organisation's easily accessible and confidential Employee Assistance Programme (EAP).

6 Service Changes

6.1 Service Coverage

The Ministry of Health's Service Coverage Schedule specifies the services a DHB must ensure are provided. This section deals with any significant exceptions that might be sought. Northland DHB seeks no such exceptions.

6.2 Service Issues

Northland DHB has no emerging service issues other than what is already covered under 6.3 or described within the context of the Northern Region Health Plan.

6.3 Service Changes

Northland DHB is not anticipating making any significant service changes in the next year, although some proposed regional changes have the potential to affect Northland DHB.

If any service changes do arise, we will follow the Service Change Protocols in the Operational Policy Framework. We will notify the National Health Board of any service changes resulting from planned service reviews or that may arise during 2014/15.

7 Performance measures

The Ministry of Health has created the DHB monitoring framework to provide the Minister and stakeholders with a rounded view of performance. It uses a range of performance markers so it is possible to 'see at a glance' how well DHBs are performing across the breadth of their activity, with measures focused on both government priorities and legislative requirements.

MoH uses four dimensions, each with their own code, to reflect DHBs' functions as owners, funders and providers of health and disability services.

Code	Dimension	Definition
PP	Policy Priorities	Achieving Government's priority goals, objectives and targets
SI	System Integration	Meeting service coverage requirements and supporting sector inter-connectedness
OP	Outputs	Providing quality services efficiently
OS	Ownership	Purchasing the right mix and level of services within acceptable financial performance

(Health Targets are covered under 2.1 Health Targets.)

There is also a developmental (DV) dimension for new measures for which baseline data is being sought to enable targets to be set in future; DHBs are not subject to performance assessment on these.

Many of these measures and targets are also used in 3 Statement of performance expectations.

Cell colouration follows MoH's system:

Name of measure	*Description of measure*	*National target or performance expectation determined by MoH*
		Target negotiated between NDHB and MoH

Performance measure		2016/17 target or performance expectation		
		Description	Target	
PP6: Improve the health status of people with severe mental illness through improved access		Ages 0-19	Total 4.63% Maori 5.01%	
		Ages 20-64	Total 5.70% Maori 9.24%	
		Ages 65+	Total 2.30% Maori 2.38%	
PP7: Improving mental health services using transition (discharge) planning		Long term clients	Provide a report as specified	
		Children and youth with a transition (discharge) plan	≥95% of clients discharged will have a transition (discharge) plan	
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds			**≤ 3 weeks**	**≤ 8 weeks**
		Mental health (NDHB services)	80%	95%
		Addiction services (NDHB & NGOs)	80%	95%
PP10: Oral Health- Mean Decayed, Missing, Filled Teeth (DMFT) score at Year 8		Ratio year 1 (2016/17)	1.00	
		Ratio year 2 (2017/18)	0.98	
PP11: Children caries-free at five years of age		Ratio year 1 (2016/17)	55%	
		Ratio year 2 (2017/18)	55%	
PP12: Utilisation of DHB-funded dental services by adolescents (school Y9 up to and including age 17)		% year 1 (2016/17)	85%	
		% year 2 (2017/18)	85%	
PP13: Improving the number of children enrolled in DHB funded dental services		0-4, % year 1 (2016/17)	95%	
		0-4, % year 2 (2017/18)	95%	
		Children 0-12 not examined, % year 1 (2016/17)	10%	
		Children 0-12 not examined, % year 2 (2017/18)	8%	
PP20: improved management for LTCs (CVD, acute heart health, diabetes, and stroke)	1 Long term conditions	Report on delivery of the actions in the Diabetes plan "Living Well with Diabetes".	Satisfactory report to be completed on time.	
	2 Diabetes services	Report on implementation of actions in the diabetes plan *Living Well with Diabetes*, and reporting on the HbA1c indicator and Diabetes Annual Reviews.	Satisfactory report to be completed on time.	
		Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1c indicator)	% of enrolled people aged 15-74 in PHOs with diabetes whose most recent HbA1c during the past 12 months is ≤64 mmol/mol	
	3 Cardiovascular health	% of the eligible population who have had their cardiovascular risk assessed in the last five years.	90%	
		% of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the last five years	90%	
		Report on delivery of the actions and milestones identified in the Annual Plan	Satisfactory report to be completed on time.	
	4 Acute heart services	% of high-risk patients who receive an angiogram within 3 days of admission ('day of admission' being day 0) by ethnicity	70%	

Performance measure		2016/17 target or performance expectation	
		Description	**Target**
		% of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS-QI ACS and cath/PCI registry data collection within 30 days	>95%
		% of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge	>95%
		Report on deliverables for acute heart services identified in the AP and actions and progress in quality improvement initiatives to support the improvement of agreed indicators as reported in ANZACS-QI	Satisfactory report to be completed on time.
	5 Stroke services	% of potentially eligible stroke patients thrombolysed	6%
		% of stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway	80%
		% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services who are transferred within 7 days of acute admission	80%
		Report on delivery of the actions and milestones identified in the Annual Plan.	Satisfactory report to be completed on time.
PP21: Immunisation coverage		% of two-year-olds fully immunised	95%
		% of five-year-olds fully immunised	≥95%
		% of eligible girls fully immunised with HPV vaccine	≥70%
PP22: Improving system integration		Report on delivery of the actions and milestones identified in the Annual Plan's system integration section *[in NDHB's case, this is section 2.3}*. Relates to having a jointly agreed (by the Northern Region) System Level Measure improvement plan, including improvement milestones, will be provided at the end of Q1 2016/17.	
PP23: Improving Wrap Around Services, Health of Older People		95% of older people receiving long-term home support have a comprehensive clinical assessment and an individual care plan (interRAI) by the end of 2016/17	
		% of people in aged residential care by facility by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment; data will be provided that demonstrates an improvement over baseline	
		% of LTCF clients admitted to an age related residential care (ARRC) facility who had been assessed using an interRAI home care assessment tool in the six months prior to that first long term care facility (LTCF) assessment; data will be provided that demonstrates an improvement over baseline	
PP25: Prime Minister's youth mental health project		Initiative 1: SBHS in decile 1 to 3 secondary schools, teen parent units and alternative education facilities. 1 Provide quarterly quantitative reports on the implementation of SBHS, as per the template provided 2 Provide quarterly narrative progress reports on actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS	

Performance measure	2016/17 target or performance expectation	
	Description	**Target**
	Initiative 3: Youth primary mental health 1 Provide quarterly narrative progress reports (as part of PP26 Primary Mental Health reporting) with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: • early identification of mental health and/or addiction issues • better access to timely and appropriate treatment and follow-up • equitable access for Maori, Pacific and low decile youth populations 2 Provide quantitative reports using the template provided under PP26	
	Initiative 5: Improve the responsiveness of primary care to youth. 1 Provide quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in local alliancing arrangements 2 Provide quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19 age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per the SLAT(s) work programme	
PP26: *Rising to the Challenge*, The Mental Health & Addiction Service Development Plan	Provide reports as specified for each focus area: • primary mental health • suicide prevention and postvention • improving crisis response services • improving outcomes for children • improving employment and physical health needs of people with low prevalence conditions	
PP27: Supporting vulnerable children	Report on delivery of the actions and milestones identified in the AP.	
PP28: Reducing rheumatic fever	Provide a progress report against NDHB's rheumatic fever prevention plan	
	Hospitalisation rate (per 100,000 DHB total population) for acute rheumatic fever	3.5/100,000
	Reports on progress in following up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever	
PP29: Improving waiting times for diagnostic services	1 *Coronary angiography* % of accepted referrals for elective coronary angiography who receive their procedure within 90 days	95%
	2 *CT and MRI* % of accepted referrals for CT scans and for MRI scans who receive their scan within 42 days	95% CT 85% MRI
	3 *Diagnostic colonoscopy* a % of people accepted for an urgent diagnostic colonoscopy who receive their procedure within 14 days and within 30 days	85% within 14 days 100% within 30 days
	b % of people accepted for a non-urgent diagnostic colonoscopy who receive their procedure within 42 days and within 120 days	70% within 42 days 100% within 90 days.
	Surveillance colonoscopy c % of people waiting for a surveillance colonoscopy who receive their procedure within 84 days and within 120 days.	70% within 84 days 100% within 120 days

Performance measure	2016/17 target or performance expectation	
	Description	**Target**
PP30: Faster cancer treatment	Part A: Faster cancer treatment – 31 day indicator. % of patients who receive their first cancer treatment (or other management) within 31 days of date of decision-to-treat	85%
	Part B: Shorter waits for cancer treatment – radiotherapy and chemotherapy % patients ready for treatment who receive treatment within four weeks from decision to treat	100%
PP31: Better help for smokers to quit in public hospitals *(previous HT)*	% of hospital patients who smoke and are seen by a health practitioner in a public hospital and offered brief advice and support to quit smoking	95%
	•	
SI1: Ambulatory sensitive (avoidable) hospital admissions (SLM Age group 0-4 years)	0-4 years	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.
	45-64 years	By 30 June 2017 halve the difference between the Northland Maori rate (7,651 /100,000) and the national total population rate (3,717 /100,000) – that is to 5,684 /100,000 – while ensuring there is no increase in Northland DHB's total population rate.
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region.	
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan that are not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or by the Ministry.	
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement	21.0 per 10,000 population
	Cataract procedures	27.0 per 10,000 population
	Cardiac surgery	6.5 per 10,000 population DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain this rate.
	Percutaneous revascularisation	12.5 per 10,000 population
	Coronary angiography services	34.7 per 10,000 population
SI5: Delivery of Whanau Ora	Performance expectations are met across all the measures associated with the five priority areas… • mental health • asthma • oral health • obesity • tobacco …and narrative reports cover the five areas.	
SI7: SLM total acute hospital bed days per capita	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.	
SI8: SLM patient experience of care	Hospital	Provide a report each quarter as specified in the measure definition.

Performance measure		2016/17 target or performance expectation	
		Description	Target
			A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.
		Primary care	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.
SI9: SLM amenable mortality		A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.	
OS3: Inpatient length of stay		Elective LOS	1.55 days, the 75th centile of national performance
		Acute LOS	2.35, the 75th centile of national performance
OS8: Reducing acute readmissions to hospital (standardised rates /100,000) *To be confirmed in 2016/17 year following an agreed definition from the sector reference group.*		Total population	
		75+	
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus area 1: Improving the quality of identity data	1 New NHI registration in error:	>1% and ≤3%
		2 Recording of non-specific ethnicity:	>0.5% and ≤2%
		3 Update of specific ethnicity value in existing NHI record with a non-specific value:	>0.5% and ≤2%
		4 Validated addresses unknown	>76% and ≤85%
		5 Invalid NHI data updates causing identity confusion	TBC
	Focus area 2: Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS	≥97% and <99.5%
		National collections file load success	≥98% and <99.5%
		Assessment of data reported to the National Minimum Data Set	≥75%
		NNPAC timeliness	≥95% and <98%
Output 1: Mental health output delivery against plan		Volume delivery for specialist Mental Health and Addiction services is within:	a 5% variance of planned volumes for services measured by FTE b 5% variance of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day c actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan
Developmental measure DV6: SLM youth access to and utilisation of youth appropriate health services			No performance target/expectation set.
Developmental measure DV7: SLM number of babies who live in a smokefree household at six weeks postnatal			No performance target/expectation set.

Appendix A: Glossary

Term	Definition or explanation
A&R	assessment and rehabilitation
AAU	Acute Assessment Unit, which takes less urgent patients from the Emergency Department (or sometimes straight from a GP) and performs further tests or stabilises them before they are transferred to a ward or sent home
ABC	a process for helping smokers to quit which consists of Ask, Brief intervention and Cessation
ACC	Accident Compensation Corporation
ACE	angiotensin-converting enzyme, a drug to control high blood pressure
ACP	advance care plan, which describes how a person wants to be treated in future, often made after receiving a diagnosis of a terminal condition
ACPP	accelerated chest pain pathway
ACS	acute coronary syndrome
ADHB	Auckland DHB
ADOM	Alcohol and other Drugs Outcome Measure
ALT	Alliance Leadership Team, also known as Te Roopu Kai Hapai Oranga (compare with SLAT)
ANZACS-QI	All New Zealand Acute Coronary Syndrome Quality Improvement
AOD	alcohol and other drugs
ARRC	age-related residential care (sometimes also 'ARC', aged residential care)
ASH	ambulatory sensitive hospitalisations; a subset of avoidable hospitalisations
ASU	acute stroke unit
B4SC	Before School Checks, performed on children as part of the Well Child Tamariki Ora schedule; includes checks on overweight and obesity that form part of the new Health Target on childhood obesity
CAMHS	Child and Adolescent Mental Health Service
CAP	Children's Action Plan
CCP	Contribution to Cost Pressures, an increase in a DHB's funding to help it deal with increasing costs
CEP	co-existing problems (in mental health and addictions)
COPMIA	children of parents with mental illness and/or addiction
CRAB	Copeland's Risk Adjusted Barometer, a tool for monitoring and demonstrating the quality of patient care
CT	computerised tomography, a type of body imager and scanner
CVD	cardiovascular disease
CYF	Child, Youth and Family (part of the Ministry of Social Development)
DAO	duly authorised officer, a person empowered to act under the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
DHB	District Health Board
DMFT	decayed, missing, filled teeth; a measure of the number of damaged teeth in a mouth

Term	Definition or explanation
DNA	did not attend
EAP	Employee Assistance Programme
ECP	emergency contraceptive pill (commonly called the 'morning after pill')
ED	Emergency Department
EIP	early intervention psychosis (within MHAS)
ELT	Executive Leadership Team
ESPI	Elective Services Performance Indicator, a series of which measure progress through the elective surgical system
FAST	Face Arm Speech Time, an acronym that helps people quickly check symptoms to see if someone is having a stroke
FCT	Faster Cancer Treatment
FDNH	First Do No Harm, a former Northern Region harm reduction programme
FFL	Fit for Life (project under Northland DHB's Northland Health Services Plan)
FLS	Fracture Liaison Service
FPSC	Finance, Procurement and Supply Chain
FSA	first specialist appointment; a patient's first appointment with a specialist after referral by their GP
FTE	full time equivalent; 40 hours per week of work time
FY	financial year; for DHBs, 1 July to 30 June (compare with CY)
GDP	Gross Domestic Product
GNS	Geriatric Nurse Specialist
GP	General Practitioner
Green Prescription	a health professional's written advice to a patient to be physically active, as part of the patient's health management
HbA1C	a measure of the amount of sugar in the blood
HBL	Health Benefits Limited; a national organisation established in 2010 to reduce costs and deliver savings in administrative, support and procurement services for the health sector. It was disestablished in 2015.
HCSS	home and community support services (for older people, to help them continue living in the community); formerly known as home based support services
HEADSSS	an international screening tool for adolescents, comprising Home, Education, Activities, Drugs, Sex, Suicidality and Safety
HoNOS	Health of the Nation Outcomes Scale
HOP	health of older people
HPA	Health Promotion Agency, a Crown entity established under the NZ Public Health and Disability Amendment Act 2000; it was established in 2012 through the merger of several smaller agencies
HPV	human papilloma virus, which can cause warts and cancers on or around the genitals
HQSC	Health Quality and Safety Commission, a Crown entity established the NZ Public Health and Disability Act 2000; it was established in 2010
HT	Health Target
HWNZ	Health Workforce New Zealand
ICNet NG	a real-time, evidence based, cross-browser software solution designed to provide

Term	Definition or explanation
	optimal support to improving infection prevention activities within the healthcare setting
ICT	intensive community team (within MHAS)
IFHC, IFHN	Integrated Family Health Centre (for urban areas), Integrated Family Health Network (for rural areas)
IBT	in-between travel, the time HCSS workers spend travelling between clients
ICP	Infection Control Practitioner
interRAI	an international collaboration of researchers that promotes evidence-based clinical practice and policy to improve health care for persons who are elderly, frail, or disabled
IPIF	Integrated Performance and Incentive Framework, the suite of national performance indicators for primary care services
IPPMR	Internal Planning, Performance Monitoring and Reporting (NDHB senior management monitoring meeting)
IPU	inpatient unit (usually in relation to mental health services at Whangarei Hospital)
IT	information technology
JADE	a computer software product (and the company that makes it)
LARC	long-acting reversible contraceptive
LMC	Lead Maternity Carer; the midwife who oversees a pregnant woman's care
LOS	length of stay (in hospital)
LTC	long term condition; includes CVD, diabetes, cancer and respiratory diseases
LTCF	long term care facility
MDM	multidisciplinary meeting; health workers of various types and specialties meet to discuss patients (often in connection with cancer)
Ministry	Ministry of Health
MoH	Ministry of Health
MHA	mental health and addictions
MHAS	Mental Health and Addiction Services of Northland DHB
MIMH	maternal infant mental health
mmol	millimole, a measure of tiny amounts used in, for example, calculating drug dosages
MoH	Ministry of Health
MRI	magnetic resonance imaging, a type of body imaging used especially for looking at body structures that do not show up well on xray
MSD	Ministry of Social Development
NASC	Needs Assessment and Service Coordination
NBHS	Newborn Hearing Screening
NBRS	National Booking Reporting System, which contains information by specialty and booking status on how many patients are waiting for elective surgery, and how long they have had to wait before receiving it
NCHIP	National Child Health Information Platform
NCN	Northern Cancer Network
NDHB	Northland District Health Board
NGO	non-government organisation (essentially any agency that isn't a government department or ministry)

Term	Definition or explanation
NHH	Neighbourhood Healthcare Homes, a project under the NHSP
NHI	National Health Index, the system of assigning unique letter-and-number codes to every patient seen in the public health system
NHSP	Northland Health Services Plan
NIF	Northland Intersectoral Forum, a group of chief executives and general managers from government organisations and TLAs
NIP	National Infrastructure Platform, a national programme to deliver infrastructure as a service (IAAS) to all DHBs
NIR	National Immunisation Register
NMDS	National Minimum Dataset, a collection of public and private hospital discharge information, including coded clinical data for inpatients and daypatients
NNPAC	National Non-admitted Patients Collection, which stores data about non-admitted face-to-face secondary care events, such as outpatient and emergency department visits
Northern Region (DHBs)	the four DHBs that cover Northland, Waitemata, Auckland and Counties Manukau (South Auckland).
NRA	Northern Regional Alliance, the shared services agency for the Northern Region
NRHP	Northern Region Health Plan
NRT	nicotine replacement therapy
OAC	oral anti-coagulant (commonly called 'blood thinners')
OECD	(United Nations) Organization for Economic Cooperation and Development
PAS	patient administration system
PCI	percutaneous revascularisation, a technique for managing heart vessel blockages with catheters
PDSA	Plan, Do, Study, Act; a tool for testing a change to see how well it has worked
PHO	Primary Health Organisation
PI	pressure injury
PMS	patient management system; the computer-based system that handles patient data
Primary Options	A programme that funds GPs to carry out minor procedures that would otherwise be done in hospital
POPS	Psychiatric Old Peoples Service
PRIMHD	Programme for the Integration of Mental Health Data, MoH's national repositry of mental health data
PUC	Purchase Unit Code, a system for grouping and coding costs
PWCC	Patient and Whānau Centred Care (programme)
Q	quarter (as in Q1, Q2, Q3, Q4) within the financial year for DHBs which runs from July to June
QSM	Quality and Safety Marker, measures monitored nationally by HQSC which include four key safety priorities: falls, healthcare-associated infections, surgical harm and medication safety
RBA	Results-Based Accountability, a framework for monitoring performance
RF	rheumatic fever
RFP	request for proposal, a form of tendering
RMO	Resident Medical Officer

Term	Definition or explanation
SLAT	Service Level Alliance Team, a collaborative cross-sectoral group focused on a particular service area (compared with ALT which takes an overview of all services and needs in the health sector)
SMO	senior medical officer (consultant, specialist)
SPC	Statistical Process Control
SPE	Statement of Performance Expectations, required of all Crown Entities under the Crown Entities Act
SSI	surgical site infection
SSRI	selective seretonin re-uptake inhibitor, a drug commonly used for treating depression
STEP	Segmentation Towards Enabling Pathways, an approach being used by MSD to improve housing quality and availability
SUDI	sudden unexpected death in infancy (sometimes also used to mean sudden unexplained death in infancy)
telehealth	the delivery of health services and information via telecommunications technologies to overcome geographic and time barriers; telehealth encompasses areas such as telemedicine, teleradiology and telemonitoring (currently at Northland DHB most telehealth uses video conferencing for clinical and educational use)
Te Pou	the national agency that supports and develops mental health, addiction and disability workforces
Te Poutoko-manawa	Northland DHB's Maori Health Team
Te Roopu Kai Hapai Oranga	Northland's Alliance Leadership Team
TestSafe	A medical information-sharing service that gives healthcare providers access to diagnostic results, reports and medicines information for their patients available through both DHB services and community pharmacies.
THOON	Te Hau Ora O Ngapuhi
TLA	territorial local authority (in Northland, the three District Councils and the Northland Regional Council)
Triple Aim	a planning model with three facets, each of which is equally important: population health, patient experience, value and sustainability
VTE	venous thromboembolism (blood clot)
WCTO	well child, tamariki ora; well-child services provided by mainstream and Maori providers
WERO	Whanau End-smoking Regional whanau Ora challenge
WO	Whanau Ora

Appendix B: Statement of Accounting Policies

The prospective financial statements have been prepared on the basis of the significant accounting policies which are expected to be used in the future for reporting historical financial statements. This appendix sets out the significant accounting policies used in the preparation of financial statements included in this Annual Plan.

Reporting entity

Northland District Health Board (Northland DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. Northland DHB has designated itself as a Public Benefit Entity (PBE) for financial reporting purposes, it is owned by the Crown and domiciled in New Zealand. Northland DHB is a reporting entity for the purposes of the NZ Public Health and Disability Act 2000, the Crown Entities Act 2004 and the Public Finance Act 1989.

The consolidated financial statements of Northland DHB and group for the year ended 30 June 2015 comprise Northland DHB, its controlled entity the Kaipara Total Health Care Joint Venture (54% owned) and its associate healthAlliance N.Z. Limited (20% owned).

Northland DHB's activities involve funding and delivering health and disability services in a variety of ways to the community.

Basis of preparation

Statement of compliance

The financial statements have been prepared in accordance with generally accepted accounting practice in New Zealand (NZGAAP). They have been prepared in accordance with Tier 1 PBE Accounting Standards. These financial statements comply with PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. The material adjustments arising on transition to the new PBE accounting standards are explained in note 23.

Measurement base

The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land and buildings to fair value.

Functional and presentation currency

The financial statements are presented in New Zealand Dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the Northland DHB and its subsidiary is New Zealand dollars (NZ$).

The accounting policies as set out below have been applied consistently to all periods presented in these consolidated financial statements.

Forecast Information

In preparation of the financial statements, the Northland DHB has made estimates and assumptions concerning future events. The assumptions and estimates are based on historical factors and other factors including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions may differ from subsequent actual results.

Factors which could lead to a material difference between the information in the forecast/plan financial results and the actual financial results prepared in future reporting periods include:

- Collective employment contract agreements settling at factors materially different from the assumptions

- Actual growth factors being materially different from the cost growth factors assumptions in the forecast financial information
- A re-estimate of the useful life or residual value of property, plant and equipment. The Northland DHB minimizes the risk of re-estimate uncertainty by such activities as physical inspection of assets, and asset replacement programmes.
- The revenue growth assumed for forecast financial years beyond 2017/18, being greater or less than the nominal increase received in the Ministry of Health funding envelope for 16/17 year.

The forecasted financial statements for the year ended 30 June 2016, incorporate the unaudited results for the five month period to November 2015.

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with PBE accounting standards requires management to make judgments, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgments about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates will be recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land and buildings revaluations

Note 10 provides information about the estimates and assumptions applied in the measurement of revalued land and buildings.

Long service leave and retirement gratuities

Note 15 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

Estimating useful lives and residual values of property, plant and equipment

The useful lives and residual values of property, plant and equipment are reviewed at each balance date. Assessing the appropriateness of useful life and residual value estimates requires Northland DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by Northland DHB, and expected disposal proceeds (if any) from the future sale of the asset.

Critical judgements in applying accounting policies

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the Northland DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

Northland DHB has exercised its judgement on the appropriate classification of leases, and has determined one lease arrangement is a finance lease.

Changes in accounting policies

The accounting policies have been updated to reflect the changes to PBE accounting standards. These updates have not resulted in any changes in accounting policies during the financial year.

Early adopted amendments to standards

There have been no early adopted amendments to standards in the current year.

Standards, amendments and interpretations issued that are not yet effective and have not been earlier adopted

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. Northland DHB has applied these standards in preparing the 30 June 2016 financial statements.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods

beginning on or after 1 April 2014. Northland DHB applied these updated standards in preparing its 30 June 2015 financial statements. Northland DHB expects there will be minimal or no change in applying these updated accounting standards.

Basis for consolidation

Subsidiaries

Subsidiaries are entities controlled by Northland DHB. Control exists when Northland DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

The consolidated financial statements include the parent (Northland DHB) and its subsidiary. The subsidiary is accounted for using the acquisition method, which involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or revenue and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements.

Investments in subsidiaries are carried at cost in Northland DHB's own "parent entity" financials statements.

Equity accounted Investees: Associates

Associates are entities over which Northland DHB has significant influence, but not control, over the financial and operating policies. Equity accounted investees are initially recognised at cost. Subsequent to initial recognition they are accounted for using the equity method in the consolidated financial statements.

The consolidated financial statements include Northland DHB's share of the profit or loss after tax of equity accounted investees from the date that significant influence commenced. Distributions received from an associate reduce the carrying amount of the investment. Where the group transacts with an associate, surpluses or deficits are eliminated to the extent of the group's interest in the associate.

Investments in associates are carried at cost in Northland DHB's own parent entity financial statements.

Budget figures

The budget figures are those approved by the Northland DHB in its Statement of Intent and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with

NZGAAP. They comply with PBE accounting standards and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by Northland DHB for the preparation of these financial statements.

Foreign currency transactions

Transactions in foreign currency are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus or deficit. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction.

Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less.

Trade and other receivables

Short-term receivables are recorded at their face value, less any provision for impairment. A receivable is considered impaired when there is evidence that Northland DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Trade and other payables

Trade and other payables are initially measured at fair value and subsequently stated at amortised cost using the effective interest rate method.

Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Equity investments

Northland DHB designates equity investments at fair value through other comprehensive revenue and expense, which are initially measured at fair value plus transaction costs.

After initial recognition, these investments are measured at their fair value with gains and losses recognised in other comprehensive revenue and expense, except for impairment losses that are recognised in the surplus or deficit.

On derecognition, the cumulative gain or loss previously recognised in other comprehensive revenue and expense is reclassified to the surplus or deficit.

A significant or prolonged decline in the fair value of the investment below its cost is considered objective evidence of impairment. If impairment evidence exists, the cumulative loss recognised in other comprehensive revenue and expense is reclassified from equity to the surplus or deficit.

Impairment losses recognised in the surplus or deficit are not reversed through the surplus or deficit.

Inventories

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost (using the average weighted cost method), adjusted, when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost (using the average weighted cost method) and net realisable value.

Inventories are stated at the lower of cost and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

Interest bearing borrowings

Interest bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis. Borrowings are classified as current liabilities unless Northland DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

- freehold land
- freehold buildings
- plant and equipment
- vehicles
- work in progress.

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and accumulated impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer every three years or where there is evidence of a significant change in fair value. The net revaluation results are credited or debited to other comprehensive revenue and is accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue but is recognised in the surplus or deficit. Any subsequent increase on revaluation that offsets a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue.

Accumulated depreciation at revaluation date is eliminated against the gross carrying amount so that the carrying amount after revaluation equals the revalued amount.

Property that is being constructed or developed for future use as investment property is classified as property, plant and equipment and stated at cost until construction or development is complete, at which time it is reclassified as investment property.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, plant and equipment vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Northland Health Limited (a hospital and health service company) were vested in Northland District Health Board on 1 January 2001. Accordingly, assets were transferred to Northland DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the health board has

recognised the cost and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the surplus or deficit is calculated as the difference between the net sales price and the carrying amount of the asset. The gain or loss is recognised in the reported net surplus of deficit in the period in which the transaction occurs. Any balance attributable to the disposed asset in the asset revaluation reserve is transferred to retained earnings.

Additions to property, plant and equipment

The cost of an item of property, plant and equipment is recognised as an asset if, and only if, it is probable that future economic benefits or service potential associated with the item will flow to Northland DHB and the cost of the item can be measured reliably.

In most instances, an item of property, plant and equipment is recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Northland DHB. All other costs are recognised in the statement of comprehensive revenue as an expense as incurred. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided using the straight line method on all property plant and equipment other than land, and recognised in the surplus or deficit.

Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	Estimated life	Depreciation rate
Buildings		
Structure	1 to 65 years	(1.5% - 100%)
Services	1 to 25 years	(4% to 100%)
Fit out	1 to 10 years	(10% - 100%)
Plant and Equipment	1 to 10 years	(10% - 100%)
Motor Vehicles	5 to 10 years	(20%)

The residual value of assets is reassessed annually to determine if there is any indication of impairment.

Work in progress is recognised at cost less impairment and is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Borrowing costs

Borrowing costs are recognised as an expense in the period which they are incurred.

Intangible Assets

Intangible assets that are acquired by Northland DHB are stated at cost less accumulated amortisation and impairment losses.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific asset.

Costs that are directly associated with the development of software for internal use, are recognised as an intangible asset. Direct costs can include the software development employee costs and an appropriate portion of relevant overheads.

The investment in the Finance and Procurement Supply Chain with Health Benefits Limited is recognised at the cost of capital invested. This is an indefinite life asset which is tested for impairment annually.

Subsequent expenditure

Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

Amortisation is provided in the surplus or deficit on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use.

Class of asset	Estimated life	Amortisation rate
Software	2 to 3 years	(33% - 50%)

Impairment of property, plant and equipment and intangible assets

Northland DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a cash return.

Intangible assets that have an indefinite useful life, or not yet available for use, are not subject to amortisation and are tested annually for impairment. Assets that have a finite useful life are reviewed for indicators of impairment at each balance date. When there is an indicator of impairment the asset's recoverable amount is estimated. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the fair value of an asset cannot be reliably determined by reference to market based evidence.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets the impairment loss is recognised in other comprehensive revenue to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Employee benefits

Defined contribution schemes

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

Northland DHB makes employer contributions to the Defined Benefits Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Long service leave, sabbatical leave and retirement gratuities

Northland DHB's obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and

prior periods. The obligation is calculated on an actuarial basis and involves the projection, on a year by year basis, of the entitlements, based on accrued service. These benefits are estimated in respect of their incidence according to assumed rates of death, disablement, resignation and retirement and in respect of those events according to assumed rates of salary progression. A value is placed on the resulting liabilities by discounting the projected entitlements back to the valuation date using a suitable discount rate. All other employee entitlements are classified as current liabilities.

Annual leave, conference leave and medical education leave

Annual leave, conference leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount Northland DHB expects to pay. These are recognised in the surplus or deficit when they accrue to employees. Northland DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Sick leave

Northland DHB recognises a liability for sick leave to the extent that compensated absences in the coming year are expected to be greater than the sick leave entitlements earned. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date to the extent the Northland DHB anticipates it will be used by staff to cover those future absences.

Bonuses

A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Provisions

A provision is recognised at fair value when Northland DHB has a present legal or constructive obligation as a result of a past event, it is probable that an outflow of economic benefits will be required to settle the obligation and that a reliable estimate can be made. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability. The movement in provisions are recognised in the surplus or deficit.

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Accredited Employers Programme

Northland DHB belongs to the ACC Accredited Employers Programme (the "Full Self Cover Plan") whereby Northland DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, Northland DHB is liable for all claims costs for a period of two years after the end of the cover period in which the injury occurred. At the end of the two-year period, Northland DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Accredited Employers Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Equity

Equity is the community's interest in Northland DHB and is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into a number of components.

The components of equity are Retained Earnings, Revaluation Reserve (consisting of Land and Buildings), non-controlling interest in the group and Trust/Special Funds. The minority interest in the group is represented by the joint venture partner in the controlled entity. Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from revenue earnings to trust funds.

Property revaluation reserve

This reserve relates to the revaluation of property, plant, and equipment to fair value.

Fair value through other comprehensive revenue and expense reserves

This reserve comprises the cumulative net change of financial assets classified as fair value through other comprehensive revenue and expense.

Revenue

The specific accounting policies for significant revenue items are explained below.

Ministry of Health population-based revenue

Northland DHB receives annual funding from the Ministry of Health, which is based on population levels within the Northland DHB region.

Ministry of Health population-based revenue for the financial year is recognised based on the funding entitlement for that year.

Ministry of Health Contract Revenue

The revenue recognition approach for Ministry of Health contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as Northland DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks. Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Goods sold and services rendered

Revenue from goods sold is recognised when Northland DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and Northland DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to Northland DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Northland DHB.

Revenue from other DHBs

Inter-district patient inflow revenue occurs when a patient treated within the Northland DHB region is domiciled outside of Northland. The Ministry of Health credits Northland DHB with a monthly amount based on an estimated patient treatment for non-Northland residents within Northland. An annual wash-up occurs at year end to reflect the number of non-Northland patients treated at Northland DHB.

Donated services

Certain operations of the Northland DHB are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by Northland DHB.

ACC contract revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Rental revenue

Rental revenue is recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental revenue over the lease term.

Interest

Interest revenue is recognised using the effective interest method.

Expenses

Operating leases

An operating lease is a lease whose term is short compared to the useful life of the asset or piece of equipment and does not transfer substantially all the risks and rewards incidental to ownership of the asset to the lessee.

Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases where Northland DHB is the lessee are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

Financing costs

Net financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method and are recognised as an expense in the financial year in which they are incurred.

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Contingent liabilities

Contingent liabilities are recorded in the Statement of Contingent Liabilities at the point at which the contingency is evident. Contingent liabilities are disclosed if the possibility that they will crystallise is not remote.

Cost of service (Statement of Service Performance)

The cost of service statements, as reported in the statement of service performance, report the net cost of services for the outputs of Northland DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost allocation

Northland DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost allocation policy

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

Direct costs are those costs directly attributable to an output class.

Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

Income tax

Northland DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Goods and services tax

All items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST inclusive basis. Where GST is not recoverable as input tax then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities is classified as an operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.